

CONFIDENTIAL FOR OFFICIAL USE ONLY

REFERRAL/AUTHORIZATION FORM

Please refer to the Provider Manual or http://www.christushealthplan.org

Authorization Request Forms that are incomplete, illegible, or do not include clinical documentation to support the request cannot be processed and will be returned to the sender for completion.

Completed forms and supporting documentation can be mailed to the address below, or emailed to Christus.hp.278@christushealth.org

CHRISTUS HEALTH	I PLAN	Louisiana		Texas	
P.O. Box 169009 Irving, Texas 75016 UM (800) 446-1730 • Fax: (800) 277-4926			Date of Request:		
Eligibility: (844) 282-					
		MEMBER INI			
Patient Name:			Patient ID:		
DOB:	Phone:		Sex:	Male Female	
		PROVIDER IN	FORMATION		
	vider:				
Contact Person Phone/Extension:					
NPI/Tax ID:					
	:	SPECIALIST/FACI	LITY REFERRI	ED TO	
Referred to:			Phone:		
Specialty:			Fax:		
NPI/Tax ID:			☐ In-Network ☐ Out-of Network		
Reason for Referral to	Out of Network Specialist or Facility	/:			
	•				
		OFFICE VISIT I	NEODMATION		
Initial Request:	☐ Visits-Consult/Treat	☐ 1 Visit-Consul			
•		i visit-consul	t Omy		
Follow Up:	Visits/Year	REQUEST FOR OT	THED SEDVICES		
Type of Service:				E ☐ Office Treatment ☐ Outpatient	
Type of Service:	☐ Observation ☐ Inpatient t	→ Home Health ←	Hospice \square Divin	E 🗀 Office Treatment 🗀 Outpatient	
Date of Procedure/Trea	atment:				
	DIA	GNOSIS/PROCEDU	JRE INFORMATI	ION	
Diagnosis:				ICD-10 Code:	
Procedure:			CPT Code:		
	TOBECO	OMPLETED BY RI	EQUESTING PHY	YSICIAN	
Clinical documentatio	n to support the request: (i.e. Physicia	n office/progress not	es, lab results, diagn	ostic/imaging results, pertinent medical/surgical history)	
Physician Signature: Date:					
Additional Comments	:				

- This Authorization is for medical necessity only and does not guarantee payment. Eligibility will be determined at the time the claim is submitted.
- Turnaround time for a routine prior authorization request is 2 business days from date/time of receipt of request.
- This Authorization is valid only for the services noted above.

 A specialist may not refer to an Out of Network specialist/facility.

 All out-of-network services require prior approval by CHRISTUS Health Plan.
- Confidentiality Notice: The information contained in this facsimile is intended only for the use of the individual or entity named above and may be privileged and confidential, protected from disclosure and re-disclosure. If the reader of this information is not the intended recipient, or an employee or agent responsible for delivering this facsimile to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please call 1-844-282-3026 in order to arrange for the return of the misdirected information. If unable to return the misdirected information, please destroy the information and notify this facility by return fax of the destruction.