CFHP Request for Services
Non STAR Kids Fax Number: 210-358-6040
Pharmacy Services Fax Number: 210-358-6385
STAR Kids Fax Number: 210-358-6274

COMMUNITY FIRST HEALTH PLANS

Texas Referral/Authorization Form

Please fill out form completely in blue or black ink. Refer to instruction sheet.

This referral does not guarantee payment. Please contact health plan to verify member eligibility and covered benefits.

☐CHIP ☐HMO ☐PPO ☐STAR ☐STAR Kids ☐UFCP ☐OTHER

☐ ROUTINE ☐ URGENT
☐ EMERGENCY
☐ OUT OF NETWORK
☐ REVISED REFERRAL
☐ NOTIFICATION ONLY

HEALTH PLAN NAME: **COMMUNITY FIRST HEALTH PLAN** DATE_____/_____/_____
Health Plan Fax# (_____)_____

PATIENT INFO.
Patient name _____
LAST FIRST MIDDLE INITIAL
DOB_____/_____/_____ Sex M☐ F☐ Phone # (___)_____

Member ID #_____ Member Social Sec. #_____

REFERRED BY
Physician name _____
LAST FIRST M.I.
Provider # _____ _____)_____
☐ PCP ☐ SCP ☐ HOSPITAL
Fax # (_____)_____Phone # ( ) _____

Contact name _____

REFERRED TO
Provider name _____
LAST FIRST M.I.

Specialty type _____ Provider/Facility # _____

Fax # (_____)_____ Phone # (_)_____

Provider City_____, Texas

REFERRED TO LOCATION

☐Office ☐Outpatient facility*** ☐Inpatient ***Note for outpatient facility, List CPT4 at right
☐ ER/Post Stabilization ☐ Other _____

Date of service_____/_____/_____

Facility name _____

Facility # *_____*Required for Therapy and Outpatient services

COMMENTS/CLINICAL HISTORY _____

_____

_____

Clinical information attached: ☐ Y / N ☐ # of pages _____

PHYSICIAN SIGNATURE- _____

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Requested Start date_____/_____/_____
Requested End date_____/_____/_____

ICD-10/DSM4/Diagnosis

Scope of referral

- ☐ Consultation
- ☐ Diagnostic Testing
- ☐ Follow-up
  Number of visits _____

SPECIFIC SERVICES REQUESTED**

****Refer to specific plan instructions.**
Certification/authorization guidelines must be followed.

- ☐ Behavioral Health
- ☐ Dialysis
- ☐ DME/Prosthesis/Supplies
- ☐ Case Mgmt. _____
- ☐ Health Educ. _____

- ☐ Home Care
- ☐ Injections and IV Therapy
- ☐ Maternity Services:

  EDC _____
  ☐ Vaginal ☐ C-Section

- ☐ Lab/Pathology
- ☐ Radiology/ Imaging
- ☐ Therapy: Indicate # of visits ___

  ☐ Physical
  ☐ Speech
  ☐ Occupational
  Visits/Week _____

- ☐ Surgery_____(CPT code)
- ☐ Assistant Surgeon

TO AUTHORIZE ONLY (OR OTHER) SPECIFIC SERVICES, INCLUDE CPT4 /MEDICAID LOCAL OR HCPCS CODES HERE.

_____ _____
_____ _____
_____ _____