CONFIDENTIAL FOR OFFICIAL USE ONLY

CHRISTUS HEALTH-US FAMILY HEALTH PLAN (USFHP)
REFERRAL/AUTHORIZATION FORM

Please refer to the Provider Manual or www.usfhp.org (select Texas/Louisiana site) for detailed authorization requirements.

US Family Health Plan
P.O. Box 924708
Houston, Texas 77292-4708
UM Voice: (800) 446-1730 • Fax: (800) 277-4926
Eligibility Voice: (800) 678-7347

Date of Request: _____

Level of Service ☐ Routine ☐ Urgent ☐ Emergency

MEMBER INFORMATION

Patient Name: _____ Patient ID: _____

DOB: _____ Phone: _____ Sex: ☐ Male ☐ Female

PROVIDER INFORMATION

Primary Care Physician: _____ Requesting Specialist: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Contact Person Name: _____ Contact Person Name: _____

Contact Person Phone/Extension: _____ Contact Person Phone/Extension: _____

SPECIALIST INFORMATION

Referred to: _____ Phone: _____

Specialty: _____ Fax: _____

Reason for Referral to Specialist: _____

Date of Last Visit/Service: _____

OFFICE VISIT INFORMATION

Initial Request: ☐ 8 Visits-Consult/Treat ☐ _____Visits-Consult/Treat ☐ 1 Visit-Consult Only

Follow Up: _____Visits/Year

REQUEST FOR OTHER SERVICES

Type of Service: ☐ Observation ☐ Inpatient ☐ Home Health ☐ Hospice ☐ DME ☐ Office Treatment ☐ ER Visit ☐ Outpatient

Date of Last Service/Treatment: _____ Phone: _____

Provider of Service/Facility: _____ Fax: _____

DIAGNOSIS/PROCEDURE INFORMATION

Diagnosis: _____ ICD-9 Code: _____

_____ _____

_____ _____

Procedure: _____ CPT Code: _____

_____ _____

_____ _____

TO BE COMPLETED BY REQUESTING PHYSICIAN

Pertinent Clinical/Previous Treatment: (Attach progress notes or test reports)

_____

_____

_____

_____

Physician Signature: _____ Date: _____

US FAMILY HEALTH PLAN UM DEPARTMENT USE ONLY

Authorization Number: _____ Expiration Date: _____ Additional Visits/Service Approved: _____

- This Authorization is for medical necessity only and does not guarantee payment. Eligibility will be determined at the time the claim is submitted.
- This Authorization is valid only for the services noted above.
- All out-of-network services require prior approval by USFHP.
- A specialist may not refer to another specialist.
- See back of form for a summary of authorization requirements.

• Incomplete Authorization Request Forms can not be processed and will be returned for completion.