CONFIDENTIAL FOR OFFICIAL USE ONLY

NEW MEXICO/TEXAS GENERATIONS (Medicare Advantage)

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. The request will be returned to the sender for completion.

CHRISTUS HEALTH PLAN
P.O. Box 169009
Irving, Texas 75016
UM 1-844-282-3026 • Fax: (800) 277-4926
Eligibility: 1-844-282-3026

Date of Request: _____

MEMBER INFORMATION

Patient Name: _____ Patient ID: _____

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

PROVIDER INFORMATION

Check Requesting Provider: ☐ Primary Care Physician ☐ Specialist

Physician Name: _____

Phone: _____

Fax: _____

Contact Person Name: _____

Contact Person Phone/Extension: _____

NPI/Tax ID: _____

SPECIALIST/FACILITY REFERRED 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 INFORMATION

Initial Request: ☐ ___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 ☐ Outpatient

Date of Procedure/Treatment: _____

DIAGNOSIS/PROCEDURE INFORMATION

Diagnosis: _____ ICD-10 Code: _____

_____ _____

_____ _____

Procedure: _____ CPT Code: _____

_____ _____

_____ _____

TO BE COMPLETED BY REQUESTING PHYSICIAN

Clinical documentation to support the request: (i.e. Physician office/progress notes, lab results, diagnostic/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 3 business days (72 hours) 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.
- See back of form for a summary of authorization requirements.

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AUTHORIZATION REQUIREMENTS

For Eligibility and Benefits, please contact Member Services at 1-844-282-3026
For Mental Health Assistance, contact Health Integrated at 1-800-323-0208

For Pharmacy Assistance, please contact:
ESI Helpdesk: 1-844-470-1531

ALL OUT OF NETWORK SERVICES REQUIRE AUTHORIZATION

Orthotics: Authorization not required for orthotics with a cost of $300 or less when furnished by a Network Provider, except:

A5500-A5513 (Diabetic Shoes, Fitting and Modification) & L3000-L3649 (Orthopedic Shoes) Require Authorization

Prosthetics: Authorization not required for prosthetics with a cost of $300 or less when furnished by a Network Provider.

Authorization Required

Outpatient Office/Facility/Home

- Chemotherapy
- Dialysis
- Home Health (Physician Review Required for Aide Requests)
- Radiation Therapy
- Rehabilitation Therapy (physical, occupational, speech, cardiac)
- Hospice-Outpatient & Continuous Care
- Selected Outpatient surgical/diagnostic procedures
- Clinical Trials
- Hyperbaric Oxygen Therapy
- Bariatric Surgery
- All out of network services

Diagnostic Services

- Cardiac Catheterization (scheduled)
- MRI/MRA
- SPECT
- Genetic Testing

**See Prior Authorization list for more.

Inpatient
Authorization Required

All elective and urgent admissions/observation stays to acute care hospitals, hospice, long term acute care, rehabilitation, skilled nursing facilities, and preoperative admissions**.**

Specialty Drugs
Authorization Required

Injectable drugs whose course of treatment is greater than $1,000 require authorization.
Examples:

Activase (Alteplase)
Aranesp (Darbepoetin)
Botox (Botulinum Toxin Type A)
Desferal (Deferoxamine)
*****Enbrel (Etanercept)
*****Growth Hormone (Somatropin)
Interferon(Avonex)
IVIG (Immune/Human Gamma Globulin)
Lucentis (Ranibizumab)
Macugen (Pegaptanib sodium)
Neulasta (Pegfilgrastim)
*****Remicade(Infliximab)
Vantas (Histrelin Implant)

***Authorization required if not dispensed through the Network Pharmacy.**

Authorization <u>NOT</u> Required

Arthroscopy
Bone Density
Capsule Endoscopy
Doppler
Echocardiogram
EEG
EMG/Nerve Conduction Studies
ERCP
Laboratory or radiology performed in the office setting and billed by a network provider
Mammogram
Surgical/diagnostic procedures performed in the office setting with no or local anesthesia
Thyroid Scan
Ultrasound
Vascular Studies (arterial/venous studies)