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CHRISTUS HEALTH-US FAMILY HEALTH PLAN (USFHP)
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 (800) 446-1730• Fax: (800) 277-4926
Eligibility: (800) 678-7347

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:

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- 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.

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-(800) 446-1730 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.

AUTHORIZATION REQUIREMENTS

For Eligibility and Benefits, please contact Member Services at 800-678-7347
For Family Planning Assistance, please contact Meritain Health, Inc. at 888-627-8889
For Mental Health Assistance, contact Health Integrated at 1-800-323-0208

For Pharmacy Assistance, please contact:

Network Pharmacies:
MAXOR Mail Order: 866-408-2459
MAXOR Pharmacy near Methodist St John Hospital: 281-480-0327
MAXOR Pharmacy at CHRISTUS Outpatient Center St.: 409-989-5643
MAXOR Pharmacy at St. Joseph Medical Center: 713-756-5300
Katy Pharmacy: 281-599-7800

Limited Network Pharmacies (urgent & first fills):
Ed's Pharmacy: 281-499-4555
Inwood Pharmacy: 281-664-8829
Market Basket Pharmacy: 409-892-3226
Randall's Pharmacy: 281-373-2507

CVS Pharmacies in Lake Charles, LA: 337-439-4241; 337-855-1341; 337-477-9068

ALL OUT OF NETWORK SERVICES REQUIRE AUTHORIZATION

Durable Medical Equipment
Authorization Required

- Alternating pressure pad/mattress
- Bone growth stimulator
- Compression/lymphedema sleeve and pump
- CPAP/BiPAP
- Continuous passive motion device (CPM)
- Customized splints
- Diabetic shoes/inserts
- Dialysis equipment
- Electric wheelchair/scooter (includes accessories, lifts & modifications)
- Hospital bed & Accessories

- Hoyer Lift
- Insulin Pump
- Oxygen & Equipment
- Standard Wheelchair
- Traction Equipment
- Ventilator & Supplies
- Implanted Neuromuscular Stimulator

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 (Tricare Policy excludes Gastric Sleeve)
- All out of network services

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

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 a USFHP Network Pharmacy.**

Authorization NOT Required

Arthroscopy
Bone Density
Capsule Endoscopy
CT Scan
Doppler
Echocardiogram (Must be performed in outpatient network hospital or facility)
EEG
ERCP
GI Scopes
Laboratory or radiology performed in the office setting and billed by a network provider
Mammogram
Nuclear Medicine Stress Test
PET Scan
Sleep Studies
Surgical/diagnostic procedures performed in the office setting with no or local anesthesia
Thyroid Scan
Ultrasound
Vascular Studies (arterial/venous studies)