

REFERRAL/PLAN AUTHORIZATION FORM

MEMBER INFORMATION:

See instructions on next page for proper completion.

MEMBER NAME (employee)

MEMBER SOCIAL SECURITY #

PATIENT NAME (last, first, MI)

PATIENT DATE OF BIRTH

MEMBER'S EMPLOYER

PATIENT SOCIAL SECURITY #

FOR REFERRALS: Complete this section and mail or fax to CHA. ALSO mail or FAX a copy to the physician or facility to which you are referring the patient (or give referral to patient to take with them).
CHA FAX number: 765.286.4375

Reason for Referral: _____

Type of Referral: _____

- Consult & recommendations only – limited to one visit
- Consult & treat – limited to two visits
- For _____ procedure
- Treatment for short-term condition – limited to ____ visits or ____ months.
- Urgent care
- Emergency care

Referred to: _____

Referring physician stamp or sign: _____

Date: ____ / ____ / ____

FOR PLAN AUTHORIZATION: Authorization MUST be obtained prior to rendering *one of the three services listed below*. Complete section below then: Mail or FAX to CHA at 765.286.4375 or PHONE information to 765.751.3060.

- Out-of-Network for _____ (cannot exceed one visit per request)
- Out-of-Network Emergency Admission and/or ER Visit
- CHS Homecare (including DME, Orthotics, Prosthetics)

PCP/Specialist must complete the following before out-of-plan treatment is approved.
Then an authorization number will be assigned by CHA Medical Management.

Diagnosis _____

Procedure _____

Justification/Indications _____

Physician Signature _____

Date: ____ / ____ / ____

Approved

Denied

Approved LOS _____

CHA Received _____

Auth # when out-of-network: _____

No labs, films or procedures out-of-network without prior approval.

QMN Signature _____

cc: _____

REFERRAL/PLAN AUTHORIZATION FORM INSTRUCTIONS

- **Member Name and SSN:** The name and social security number of the policyholder.
- **Patient Name and Birth Date:** The name and birth date of the person to receive care (may be a dependent of the member, therefore name may be different than the “member.”)
- **Employer of Member:** Where does the member (cardholder) of the plan work? (e.g. Cardinal Health System, Borg Warner Automotive)
- **Dependent Number:** Dependents are issued a different number than the policyholder’s number. Indicate the dependent SSN or his plan number on patient name line.
- **Reason for Referral:** Brief narrative explanation/indication by the requesting physician for the referral.
- **Type of Referral:** Must check one of the boxes indicating the level of treatment requested: If box “Treatment for short-term condition” is marked, the PCP must write in number of visits or period of time requested.
- **Referred To:** Name of the CHA provider for which service is being requested.
- **Referred By:** MUST BE THE SIGNATURE OF THE PCP & DATE MUST BE WRITTEN IN.
- **Urgent Care of Emergent Care:** Referral form must be completed and forwarded to CHA within two working days. Members are directed to notify their PCP if they went to an ER (on their own) and to request form notification to CHA. Claims for Emergency treatment of conditions not meeting criteria for a “medically necessary emergency” will be denied. Out-of-Plan ER does not require a referral before seeking treatment. However, continued care outside the Plan does require prior authorization. Upon returning from out-of-plan, member must notify the PCP of the out-of-plan ER visit, the date of service and place of service so that PCP has the information to forward to CHA.
- **Durable Medical Equipment (DME):** All items should be ordered through CHS Homecare.
- **For Plan Authorization:** One (1) of the three (3) boxes must be marked.
- **PCP/Specialist:** Must complete this section when requesting out-of-plan treatment.
- **Diagnosis and Procedures:** The requesting physician must write the patient’s diagnosis and the procedure for which out-of-plan authorization is being requested.
- **Justification/Indications:** Explain or indicate why the request is being made for authorization or procedure, admission, and/or services for out-of-plan. *SIGNATURE & DATE REQUIRED.*
- **Approval:** Must be marked by CHA and a copy with authorization must be in your (MD) office before member is referred out-of-network.
- **Denial:** Will be marked with a denial authorization number if out-of-network is requested and not approved by the Medical Director of the plan.
- **Labs:** If no labs are marked that means no labs/procedure out-of-network without approval.