RightCare
SCOTT & WHITE HEALTH PLAN
The one Texans trust.

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 ❑ EPO ✓ HMO ❑ PCCM ❑ POS ❑ PPO ❑ W/C ❑ OTHER _____

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

HEALTH PLAN: RightCare Medical Management DATE ____/____/____
Health Plan Fax# (512) 383-8703

PATIENT INFO.

Patient name _____
LAST FIRST MIDDLE INITIAL

DOB _____/_____/_____ Sex M❑ F❑ Phone # (____)_____

Member ID #_____ Member Social Sec. # _____-_____-_____
OPTIONAL

Requested Start date ____/_____/_____
Requested End date ____/_____/_____

ICD-9/DSM4/Diagnosis_____
_____

Scope of referral

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

REFERRED BY

Physician name _____
LAST FIRST M.I.

Provider # _____ ❑ PCP ❑ SCP ❑ HOSPITAL

Fax # (_____)_____

Contact name _____ Phone # (_____)_____

REFERRED TO

Provider name _____
LAST FIRST M.I.

Specialty type _____ Provider/Facility # _____

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

Provider City _____, Texas

REFERRED TO LOCATION

❑ Office ❑ Outpatient facility*** ❑ Inpatient ❑ 23 Hour observation
***Note for outpatient facility, List CPT4 at right
❑ ER/Post Stabilization ❑ Other Date of service _____/_____/_____

Facility name _____

Facility # * _____ * Required for ER/UCC, Therapy and Outpatient services.

COMMENTS/CLINICAL HISTORY _____

_____

_____

_____

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

PHYSICIAN SIGNATURE- _____

The information contained in this form is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

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 ❑ Cardiac Rehab
❑ Speech ❑ Occupational
Visits/Week _____

❑ Surgery _____(CPT4 code)
❑ Assistant Surgeon

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

_____ _____
_____ _____
_____ _____

HEALTH SERVICES RESPONSE

❑ Approved as requested Authorization # _____
Expiration date _____/_____/_____
Days authorized _____

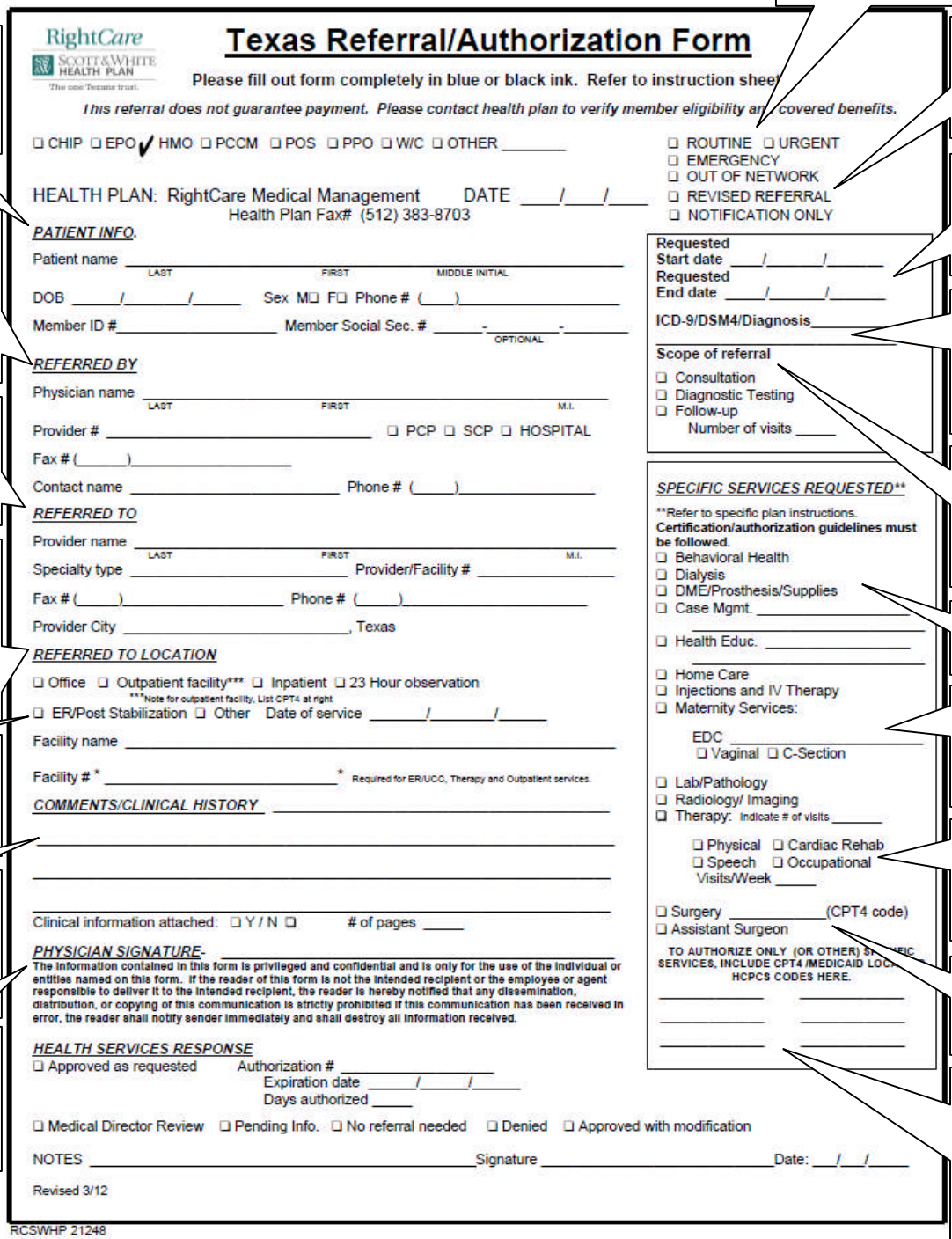
❑ Medical Director Review ❑ Pending Info. ❑ No referral needed ❑ Denied ❑ Approved with modification

NOTES _____ Signature _____ Date: ___/___/_____

Revised 3/12

Texas Referral/Authorization Form Instructions

Please fill this form out completely and submit to RightCare by faxing the completed form to 512-383-8703.



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❑ ROUTINE ❑ URGENT
❑ EMERGENCY
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❑ NOTIFICATION ONLY

HEALTH PLAN: RightCare Medical Management DATE ____/____/____
Health Plan Fax# (512) 383-8703

PATIENT INFO.

Patient name _____ (LAST / FIRST / MIDDLE INITIAL)

DOB ____/____/____ Sex M❑ F❑ Phone # (____)_____

Member ID #_____ Member Social Sec. # _____-_____-_____ (OPTIONAL)

REFERRED BY

Physician name _____ (LAST / FIRST / M.I.)

Provider # _____ ❑ PCP ❑ SCP ❑ HOSPITAL

Fax # (____)_____

Contact name _____ Phone # (____)_____

REFERRED TO

Provider name _____ (LAST / FIRST / M.I.)

Specialty type _____ Provider/Facility # _____

Fax # (____)_____ Phone # (____)_____

Provider City _____, Texas

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_____

_____

_____

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

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NOTES _____ Signature _____ Date: ___/___/____

Revised 3/12

RCSWHP 21248

Requested Start date ____/____/____
Requested End date ____/____/____

ICD-9/DSM4/Diagnosis _____
_____

Scope of referral
❑ Consultation
❑ Diagnostic Testing
❑ Follow-up
Number of visits _____

SPECIFIC SERVICES REQUESTED*

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❑ Home Care
❑ Injections and IV Therapy
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EDC _____
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❑ Lab/Pathology
❑ Radiology/ Imaging
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❑ Physical ❑ Cardiac Rehab
❑ Speech ❑ Occupational
Visits/Week _____
❑ Surgery _____(CPT4 code)
❑ Assistant Surgeon

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

_____ _____
_____ _____
_____ _____

Enter member's full Name, DOB, and Member ID as shown on member's ID card

Enter member's PCP's full name, Provider number (TPI or NPI), and fax number, and contact name and phone number

Enter the specialist name, provider number, fax number, and phone number

Enter the referred to facility's and/or provider's Name, type of location, Date of Service, TPI/NPI, and fax and phone number

Prior Authorization is not required for emergency services provided in an Emergency Room

Enter comments and/or clinical history. If clinical information is attached, please indicate this with the checkbox

The referring physician must sign this form or a signed prescription must be submitted with this form

Use TDI definitions for Routine, Urgent, or Emergency

Check this box for an addition, deletion, or extension to an Existing Referral

Enter the requested start and end date for services using the MM/DD/YYYY format

Enter the most appropriate ICD diagnosis code or write a description of the diagnosis

Prior Authorization is not required for referrals to in-network specialists made by the member's PCP

Check the specific services being requested

Enter the EDC and the type of delivery fields for maternity authorization requests

Enter the total # of visits requested, the type of therapy requested, and the total visits/week

If requesting surgery, include the appropriate CPT code for the surgery

List all CPT or HCPCS codes requiring prior authorization here or in the Comments Field. Include quantity for each code requested if more than one is being requested

Note: For services requiring prior authorization, a completed form must be received by RightCare at least 2 business days before the requested services are provided. For services requiring notification, a completed form must be received by RightCare within 1 business day after the requested services are provided. Failure to timely submit a completed form to RightCare may result in the denial of days.