Behavioral Health Referral/Authorization Form

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE PLAN
RIGHTCARE

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.

DATE ____/____/____

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 # (_____)_____

Address (Street, City, State & Zip): _____

_____

REFERRED TO

Provider name _____
LAST FIRST M.I.

Specialty type _____ Provider/Facility # _____

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

Address (Street, City, State & Zip): _____

_____

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.

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.

HEALTH SERVICES RESPONSE

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

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

Signature _____Date: ___/___/_____

COMMENTS/CLINICAL HISTORY

❑ ROUTINE
❑ OUT OF NETWORK
❑ REVISED REFERRAL
❑ NOTIFICATION ONLY
❑ ELECTIVE
❑ EMERGENT/LIFE-THREATENING
DEFINE CONDITION: _____
_____
❑ URGENT DEFINE CONDITION: _____
_____

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

ICD-9/DSM4/Diagnosis_____
_____

Scope of referral

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

COMMENTS/CLINICAL HISTORY

Clinical information attached: ❑ Y / N ❑

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

TEXAS Health and Human Services
TEXAS STAR Your Health Plan ★ Your Choice

Behavioral Health Referral/Authorization Form Instructions

Use HHSC definitions for Routine, Urgent, or Emergency

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

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

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

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

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

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

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

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

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

Address must be complete for the "Referred By" and "Referred To" Sections

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

Scott&White HEALTH PLAN
RIGHTCARE

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DATE ____/____/____

COMMENTS/CLINICAL HISTORY

- ❑ ROUTINE
- ❑ OUT OF NETWORK
- ❑ REVISED REFERRAL
- ❑ NOTIFICATION ONLY
- ❑ ELECTIVE
- ❑ EMERGENT/LIFE-THREATENING
  DEFINE CONDITION: _____
- ❑ URGENT DEFINE CONDITION: _____

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 # (_____)_____

Address (Street, City, State & Zip): _____

Requested Start date ____/_____/_____

Requested End date _____/_____/_____

ICD-9/DSM4/Diagnosis_____

Scope of referral

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

REFERRED TO

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

Specialty type _____ Provider/Facility # _____

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

Address (Street, City, State & Zip): _____

COMMENTS/CLINICAL HISTORY

Clinical information attached: ❑ Y / N ❑

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 _____/_____/_____

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Signature _____Date: ___/___/_____

TEXAS Health and Human Services | TEXAS STAR Your Health Plan * Your Choice

RCSWHP 7144

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.