TexanPlus®
A WellCare Company

TexanPlus® HMO
P.O. Box 18149
Austin, TX 78760-8149

Fax to: 713-973-2193
Phone: 713-407-3021 or
713-407-3015

Authorization Request Form

Date:_____ IPA/LPO _____

This request will be treated as per the standard organization determination timeframes. **If the request needs to be treated as expedited, please provide justification** that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function:

_____

_____

Patient Name:	DOB:	PCP:	
Member ID#:		Member Phone #:	
Member Address:	City:	State:	Zip:
Referral Type: ☐ Inpatient Admit ☐ Outpatient Surgery ☐ Home Health (SN/ST/PT/OT) ☐ DME ☐ OP Therapy (ST/PT/OT) ☐ Office Visit ☐ Observation ☐ Other:			
Diagnostic Procedure/Testing:			
Referring Physician:	Specialty:		
Address:	City:	State:	Zip:
Phone #:	Fax #:		
Contact Person:			
Requested Provider/Facility:	Phone #:	Fax #:	
Address:	City:	State:	Zip:
If Referring Out-of-Network Please State Reason:			

Requested Procedure Description:	
CPT Code:	Requested Procedure Date:
Additional Procedure(s):	CPT Code(s):
Primary Diagnosis/Rule Out:	Date of Last Office Visit:
Secondary Diagnosis(es):	
Primary Diagnosis/Rule Out:	ICD – 10 Code:
Secondary Diagnosis(es):	ICD – 10 Code(s):

****PLEASE INCLUDE CLINICAL DOCUMENTATION WITH REQUEST****

ALL REFERRALS FOR HMO PLAN MEMBERS MUST BE MADE TO CONTRACTED PROVIDERS

ALL LABWORK MUST BE SENT TO: Quest Diagnostics or other in-network lab provider.

Send Claims to: SelectCare of Texas, P.O. Box 17900, Austin, TX 78760-7900

Y0067_MM_AUTHREQ_0916_IA 09/21/2016 MCA – HMO