Texas Community Care

Medical Referral /Authorization
Phone: 800.998.3057
Fax: 877.267.8470

Pharmacy Referral /Authorization
Phone: 800.301.1317
Fax: 866.258.2828

Check One: ☐ **ROUTINE** ☐ **URGENT** ☐ **EXPEDITED** (regular response time would SERIOUSLY jeopardize the life/health of the patient)

Patient Name			**Patient Phone**
Patient Requested Referral Yes No	**Member ID Number**	**Sex**	**DOB / /**
ICD-9 Code(s):	**Diagnosis:**		

MEDICAL AUTHORIZATION REQUEST

REFERRED FROM PHYSICIAN

Name_____

Phone_____ **Fax**_____

REFERRED TO PHYSICIAN

Name_____

Phone_____ **Fax**_____

Specialty_____

FACILITY

Name_____

Phone_____ **Fax**_____

Admit Date/DOS _____/_____/_____

REQUESTED PROCEDURE(S)

☐ **INPT** ☐ **INPT REHAB** ☐ **OBS** ☐ **OUTPT** ☐ **SNF** ☐ **LTAC**

Diagnostic/Surgical Procedure / CPT Code(s):

DME/Supplies
HCPCS Code(s):

Home Health: **# of Visits**

PT/OT/ST: **# of Visits**

PHARMACY EXCEPTION REQUEST

PRESCRIBING PHYSICIAN

Name_____

Address_____

City/State/Zip:_____

Phone_____ **Fax**_____

Specialty_____

License # _____ **DEA#** _____

MEDICATION

Name & Strength:

Quantity:

Direction for Use and Duration:

Formulary Medications Tried (w/dates):

Justification for Requested Medication or Quantity Exception:

Dispensing Pharmacy:
☐ **Retail** ☐ **Specialty**
☐ **Mail Order** ☐ **Long Term Care**

SPECIFIC CLINICAL EXPLANATIONS to support the reason for the request and attach pertinent supporting documentation (If Expedited, please document the serious health consequences the patient would experience if the routine authorization process were followed):

Physician Signature: **Date:**

LIMITATION OF COVERAGE: *Coverage for any authorized request is contingent on eligibility at the time of service as well as the limits of the benefit plan*