TexanPlus® HMO
Medicare Advantage Health Plans

TexanPlus® HMO
P.O. Box 740444
Houston, TX 77274-0444

Fax to: **877-218-4872**

Authorization Request Form

☐ ROUTINE DATE: _____

☐ EXPEDITED* - *based on the urgency of the* ***member's health condition***

*The referring provider or member believes that an expedited determination is warranted when the standard decision time frame may jeopardize the member's health or ability to regain maximum functioning.

IPA/LPO _____

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)

☐ Consultation ☐ Follow-up Visit ☐ Consult & 1 Follow-up ☐ Other: _____

Diagnostic Procedure: _____ ☐ CT/CTA ☐ MRI/MRA ☐ PET Scan

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/POD Please State Reason: (A Peer to Peer may be necessary)		

Requested Procedure Description:	CPT Code:	Requested Procedure Date:
Additional Procedure(s):	CPT Code(s):	
Primary Diagnosis/Rule Out:	ICD-9 Code:	Date of Last Office Visit:
Secondary Diagnosis(es):	ICD-9 Code(s):	
Primary Diagnosis/Rule Out: Only required if DOS is after 9-30-14.	ICD-10 Code:	
Secondary Diagnosis(es): Only required if DOS is after 9-30-14.	ICD-10 Code(s):	

Determination Date:	**Expiration Date:**
Authorization Number:	**Reviewer:**

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 741107, Houston, TX 77274