



**REFERRAL MUST BE FAXED OR MAILED TO
CHNCT FOR AUTHORIZATION PRIOR TO
INITIAL VISIT**

11 Fairfield Boulevard
Wallingford, CT 06492
Fax # 1-203-265-3994
Phone # 1-800-440-5071

Out Of Network / Out Of State Referral Authorization Request Form

MEMBER		REFERRING PRIMARY CARE PROVIDER	
ID#:	Date of Birth:	Last Name:	First Name:
Last Name:	First Name:	Referral Contact:	
Address:	Phone #:	Group/Office Name:	
		Site/Address:	
		Phone #:	Ext:
		Fax #:	
		PCP Signature:	Date of Referral:

CONSULTANT

Last Name:	First Name:	Specialty:	
Place of appointment/Address:		Contact:	
NPI#:	Tax ID#:	Phone#:	Ext:
		Fax #	
		Appointment date/time:	

REASON FOR REFERRAL

Diagnoses Code:

Description:

History/Reason for referral:

Second Request ER Referral Continuity of Care In network provider not available Other

*Please Include Clinical Notes with referral

***For a directory of participating providers, please see our website at www.CHNCT.org

REFERRAL POLICY FOR CONSULTANT

- **VERIFY MEMBER ELIGIBILITY BEFORE DELIVERING SERVICES.**
- **REFERRALS ARE SUBJECT TO REVIEW OF MEDICAL NECESSITY.**
- **REQUESTS FOR ADDITIONAL SERVICES MUST COME FROM THE PCP AND REQUIRE CHNCT PRIOR AUTHORIZATION.**
- **AUTHORIZATION IS BASED ON MEDICAL NECESSITY AND IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON MEMBER ELIGIBILITY, BENEFIT COVERAGE AND POLICIES IN EFFECT AT THE TIME OF SERVICE.**
- **PROVIDER AGREES TO ACCEPT CHNCT REIMBURSEMENT AS PAYMENT IN FULL FOR HUSKY A, HUSKY B OR SAGA PARTICIPANTS.**
- **REFER TO THE CHNCT PROVIDER MANUAL FOR MORE DETAIL.**

FOR CHNCT CARE MANAGEMENT DEPARTMENT USE ONLY

Eligibility Date:	<input type="checkbox"/> Approved	Start Date:	# vts:
Authorization #:	<input type="checkbox"/> Denied		
	<input type="checkbox"/> Pended	End Date:	Initials:

ATTENTION SPECIALIST: CALL 1-800-440-5071 PRIOR TO THE FIRST APPOINTMENT FOR AN AUTHORIZATION NUMBER IF WRITTEN CONFIRMATION HAS NOT BEEN RECEIVED FROM CHNCT.