COMMUNITY HEALTH NETWORK
OF CONNECTICUT, INC.®
11 Fairfield Boulevard, Wallingford, CT 06492
800-440-5071 Fax (203) 265-3994 www.chnct.org

CHNCT OUT OF STATE LAB/RADIOLOGY REQUEST FORM

Member's Name: ______________________________ Date of Birth: ________________

Member's ID: ☐☐☐☐☐☐☐☐☐ Plan: Husky_______ Charter Oak__________

Date of Service:______________________ Hospital:___________________________

Referring Physician:____________________ Name of Contact:______________________

Phone:_____________________________ Fax:_______________________________

Name of Procedure:____

Proc Code:__________________________ Diag Code:____________________________

Reason for out of state service: ____

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Clinical notes must be faxed to CHNCT for review
Please fax request to 203-265-3994. Thank You

****PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF ALL CLINICAL INFORMATION TO PROCESS REQUEST****