



**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

Referral Authorization Request Form

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

CONSULTANT

Last Name:	First Name:	Specialty:	
		Phone#:	Fax #
Place of appointment:		Appointment date/time:	

REASON FOR REFERRAL

Diagnoses:

History/Reason for 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.

Please add statement:

Please fax referral requests 48 business hours prior to appointment.