



**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			
<ul style="list-style-type: none"> • 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	End Date: Initials:
	<input type="checkbox"/>	Pended	

Copy Distribution: White – Consultant Yellow – Community Health Network Pink – PCP 4/04

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.