Specialist Consultant
Appointment Form

Community Health Choice (Community) does not require authorization for an in-network specialty provider. Complete form only if you need assistance with a Specialist request.

Date:____/ ____/____ Time: _____:_____ ☐a.m. ☐p.m.

Provider Information			
Last Name:	First Name:		
Type of Specialist Needed: ☐ Urgent ☐ Routine ☐ Stat		Does this Member need additional specialty Providers? ☐ Yes ☐ No If yes, please complete a separate form.	
Office Name:	Contact:		
Phone:	Fax:	E-mail:	

Member Information			
Last Name:	First Name:		
DOB:	Member ID:	Language:	Need Transportation: ☐ Yes ☐ No
Address:	City/State:	ZIP:	
Is Member Pregnant? ☐ Yes ☐ No	Guardian Name:		

Clinical Information	
Diagnosis:	ICD Code:
Clinical Notes:	

~ For Internal Use Only ~

Specialist Information

(Community will complete and return to referring physician.)

Last Name:	First Name:	
Address:	City/State:	ZIP:
Phone:	Fax:	Specialist Appt. Date/Time:

Fax to the Community Specialist Scheduler at **713.295.7050.**

Print Form