

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:		Does this Member need additional specialty Providers? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Urgent <input type="checkbox"/> Routine <input type="checkbox"/> Stat		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: <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:		City/State:	ZIP:
Is Member Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Guardian Name:		
<input type="checkbox"/> HMO D-SNP <input type="checkbox"/> Marketplace <input type="checkbox"/> Medicaid/CHIP <input type="checkbox"/> STAR+PLUS			
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 **713-295-2293**.