

**TODAY'S OPTIONS PPO  
REFERRAL/AUTHORIZATION REQUEST FORM**

**1 – MEMBER INFORMATION:**

Member Name: _____	Date of Request _____
ID#: _____	Date Of Birth _____
Member Address: _____	Mbr Telephone:(____) _____
_____	PCP: _____

**2 – REFERRAL TYPE:**

<input type="checkbox"/> Routine	<input type="checkbox"/> Expedited	
<input type="checkbox"/> Inpatient Admit	<input type="checkbox"/> Outpatient Surgery	<input type="checkbox"/> Diagnostic Procedure
<input type="checkbox"/> DME	<input type="checkbox"/> Home Health Care	<input type="checkbox"/> Other (Specify) _____

**3 – PROVIDER AND CLINICAL INFORMATION:**

Requested Provider /Facility Name: _____		
Address: _____		
Phone#: _____	FAX#: _____	
Primary Diagnosis: _____	ICD-9: _____	
Secondary Diagnosis: _____	ICD-9: _____	
Primary Procedure: _____	Date: _____	CPT: _____
Additional Procedure(s): _____		
Other clinical Information: _____		
_____		
Requesting Provider: _____	Phone#: (____) _____	
Referral Completed By: _____	Fax#: (____) _____	

*THIS AUTHORIZATION FOR MEDICAL SERVICES IS NOT A GUARANTEE OF ELIGIBILITY OR PAYMENT.*

**4 – FOR PLAN USE ONLY:**

Pended Date: _____	Time: _____	
Approved Date: _____	Time: _____	
Denied Date: _____	Time: _____	
Authorization Number: _____		
Decision Made by: <input type="checkbox"/> Coordinator	<input type="checkbox"/> Nurse	<input type="checkbox"/> Medical Director

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Send Claims to:

**Today's Options PPO  
P.O. Box 742568, Houston, TX 77274**