Primary Care by Specialist Request Form

Texas Children's® Health Plan

Member's name: _____

Date of birth: _____ Member number: _____

Parent/guardian's name: _____

Primary HMO: _____

Primary care physician name: _____

Specialist name: _____ Specialty: _____

Diagnosis: _____

Please write a brief description of the reasons you would like the specialist to provide primary care.

_____

_____

I request the above change and hereby give the specialist noted and my current primary care physician permission to release medical records that may be needed in support of my request.

_____ _____

Signature, Member (if over 18)/Parent or guardian Date signed

I certify that it is medically necessary for me to be this member's primary care physician and that I will provide primary care services for this member to include coordination of all the member's health care needs, preventive care examinations, immunizations, and treatment of minor intercurrent illnesses. I further certify that I will accept the same contractual obligations, rates, and payment methodologies as the primary care provider.

_____ _____

Signature, Specialist Date signed

Specialist telephone number: _____

Fax to Texas Children's Health Plan at 832-825-8750

Date received: _____ Date notified of decision: _____

Review by Medical Director

☐ Approved ☐ Denied

List Reason:

_____

_____

_____ _____

Signature, Medical Director Date signed