Specialist Consultant
Appointment Form

COMMUNITY HEALTH CHOICE
COMMUNITY CARES

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

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