

**Mercy Health Plans
Referral FAX Request Form
PLEASE FAX TO: 956-723-8246**

****These forms are for Physician to Physician referrals ONLY*
All Prior Authorization requests need to be called into
1-800-647-2240**

Today's Date: _____ Referral # (assigned by MHP): _____
Member Name: _____ ID#: _____

Primary Care Physician Information

Physician Name: _____ Contact Name: _____
Phone Number: _____ FAX Number: _____

Participating Specialist

Specialist Name/Type: _____ FAX: _____

Requested Services, INCLUDING number of visits and expiration date (*If no visits and time frames are specified, the referral will be for 3 visits and set to expire in 90 days.

ICD-9 Diagnosis Code (Reason for Referral) : _____

For MHP Response ONLY: _____

NUMBER OF VISITS: _____ **EXPIRATION DATE:** _____

No referrals or authorizations are needed for IN-NETWORK mental health/substance abuse services, lab work, non-invasive x-rays (including but not limited to CT Scans, MRIs, and nuclear medicine studies), EEGs, EKGs, echocardiograms, PFTs, outpatient chemotherapy, outpatient radiation therapy, outpatient dialysis, urgent care center services, additional maternity services after initial referrals is issued, annual routine eye exams and ancillary and consultative services provided during an approved inpatient admission; (for Texas residents: all OB/GYN , Dermatology, or Orthopedic Specialists)