Texas Children's® Health Plan
The best decision a family can make.

Request for Appointment Assistance

Fax to Texas Children's Health Plan at 832-825-9455

Referring physician information

Primary care provider's name: _____ (*First* / *Last*)

Date: _____ Time: _____

Office name: _____

Contact person: _____

Contact phone #: _____

Contact fax #: _____

Patient/ member information

Patient/member name: _____ (*First* / *Last*) D.O.B.: _____ ☐ Male ☐ Female

Medicaid/CHIP ID#: _____ Language preference: _____

Parent/guardian name (if patient/member is under 18):_____

Residential address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work: _____ Cell: _____

Additional information

Type of referring specialist: _____ Preferred specialist name: _____

Reason for referral assistance: _____

Describe medical/health condition/risk: _____

(Member will be contacted within 2 days.)

Only complete if referring other family members

	Patient/member #2	Patient /member #3	Patient /member #4
Type of referring specialist			
Patient /member name:			
Medicaid #:			
DOB:			
Gender			
Medical / health condition			

Specialist Information

(Texas Children's Health Plan to complete and return to PCP via fax)

First name: _____ Last name: _____

Address: _____ City: _____State: _____ Zip: _____

Phone#: _____

Specialist appointment*(Date and time)*:_____(a.m. / p.m.)
(*Date* / *Time*)

2450 Holcombe Boulevard, Suite 34L
Houston, Texas 77021 | 1-877-213-5508

Find a referring specialist in your area at TexasChildrensHealthPlan.org/find_a_doctor.