Ascension
Personalized Care

Ascension Care Management
Insurance Holdings

Prior Authorization Form
Fax to: (512) 380-7507

Referral Type:
☐ **Routine**
☐ **Urgent, based on medical necessity urgency**

***Request Date:**	***Submitted by (Name):**
***Phone # and Ext (Include area code):**	***Return Fax # (include area code):**
***Patient Name:**	
***DOB:**	***Patient's ID Number:**
***Requesting Provider or Clinic name:**	**NPI & TIN**
***Requested Specialist or Service:**	**NPI & TIN**
***Requested # of visits:**	***Proposed Date of Service:**
***ICD-10 Codes:**	***Diagnosis Description:**
***CPT or HCPCS Codes:**	***Description:**
***Facility Name (for Inpatient or Outpatient Services):**	**NPI & TIN**

*☐ **Inpatient** ☐ **Outpatient** ☐ **Observation** ☐ **In Office** ☐ **Imaging** ☐ **DME/Home Health** ☐ **Therapy**

***Reason for referral (please attach pertinent clinical/progress notes or provide clinical narrative, including duration of problem, types of treatment, pertinent physical findings, pertinent testing results)**

Coordination of Benefits (Other Insurance)

***Workman's Compensation**	☐ YES ☐ NO	***MVA Subrogation:**	☐ YES ☐ NO	**Date of Injury:**	
***Other Insurance Coverage:**	☐ YES ☐ NO	**Name of Insurance:**		**Subscriber Name and ID #:**	

TO BE COMPLETED BY ASCENSION CARE MANAGEMENT INSURANCE HOLDINGS MEDICAL MANAGEMENT SERVICES

Authorization Number:	**Authorization Dates:**
Number of Visits or Services Approved:	

Comments/Questions:

Authorization is based on medical necessity determination and is not a guarantee of benefit coverage.

*** To process request, all required fields with asterisks must be completed.**