

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.					
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