Ascension
Personalized Care

Please complete this form in its entirety. Any omitted fields (other than the optional information) will result in this request being incomplete and unable to be processed

REQUEST FOR VERIFICATION

Date of Request:			
Provider Name:			
Provider Contact:			
Provider Phone Number:		**Fax Number:**	
Provider Address:			
Enrollee Name:			
Enrollee ID Number:		**Enrollee DOB:**	
Name of Enrollee/Subscriber:			
Enrollee relationship to enrollee/subscriber (check one): ☐ Self ☐ Spouse ☐ Child ☐ Grandchild ☐ Other			
Presumptive diagnosis or presenting symptoms:			
Procedure code(s) or description of proposed procedure(s):			
Place of Service:			
Proposed date of service:		**Group Number:**	
If known to the provider, name and contact information of any other carriers:			
Carrier's Name:			
Carrier's Address:			
Carrier's Telephone Number:			
Name of Enrollee:			
Plan or ID Number:		**Group Number:**		**Group Name:**	
Name of provider providing the proposed service:		**Provider's NPI:**	
If already obtained, precertification and/or referral number for proposed services:			

PLEASE FAX COMPLETED FORMS TO 512-380-7507

Upon completion of processing, providers will receive a fax notice of the verification.