Ascension
Personalized Care
Texas Plans Only

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

*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:			
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:			

This section is completed by the Health Plan

Verification ☐Yes ☐No Declination ☐Yes ☐No	Verification Number: Declination Number: User Warning Message Assigned: ☐Yes ☐No
Member Responsibility: Deductibles copayments, or coinsurance	

PLEASE FAX COMPLETED FORMS TO 512-380-7507 or CALL 1-844-995-1145

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