| ASCENSION PERSONALIZED CARE<br>Seton Health Plan<br>A member of the Seton Healthcare Family | **Prior-Authorization Form**<br>**Fax to:** (512) 380-7407 | **Referral Type:**<br>☐ **Routine**<br>☐ **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:** | |
| ***Requested Specialist or Service:** | | **NPI:** | |
| ***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:** | |

***☐ 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 SETON HEALTH PLAN 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.**