


ASCENSION PERSONALIZED CARE  Seton Health Plan <small>A member of the Seton Healthcare Family</small>	Prior-Authorization Form Fax to: (512) 380-7407	Referral Type: Routine Urgent, based on medical necessity urgency
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*Request Date:	*Submitted by (Name):
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*Phone # and Ext (Include area code):	*Return Fax # (include area code):
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*Patient Name:

*DOB:	*Patient's ID Number:
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*Requesting Provider or Clinic name:	NPI:
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*Requested Specialist or Service:	NPI:
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*Requested # of visits:	*Proposed Date of Service:
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*ICD-10 Codes:	*Diagnosis Description:
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*CPT or HCPCS Codes:	*Description:
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*Facility Name (for Inpatient or Outpatient Services):	NPI:
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* Inpatient	Outpatient	Observation	In Office	Imaging	DME/Home Health	Therapy
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***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:	
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*Other Insurance Coverage:	YES NO	Name of Insurance:		Subscriber Name and ID #:	
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TO BE COMPLETED BY SETON HEALTH PLAN MEDICAL MANAGEMENT SERVICES

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