Ascension
Personalized Care

Ascension Personalized Care Utilization Management (UM) FAQs

1. Who is Seton Health Plan?
Ascension Personalized Care has partnered with Seton Health Plan to provide utilization review for all services that require prior authorization. Seton Health Plan is a wholly owned affiliate of Ascension Seton.

2. How can I find out if authorization is required?
A full list of services that require prior authorization is posted to ascensionpersonalizedcare.com. You can also call Ascension Personalized Care customer service at (833) 600-1311 or call Seton Health Plan directly at (877) 312-9835 to obtain information regarding which services require prior authorization.

3. How can I submit prior authorization for my patient?
Prior authorization for all services can be submitted by:

- By Fax

  Fax a completed prior authorization form to: 512-380-7407

- By Phone

  Call Seton Health Plan at 877-312-9835 (Monday -Friday 8 AM – 7 PM ET)

- By Email

  Email Seton Health Plan at shp-authorization@ascension.org

4. How can I view the status of a prior authorization?

- By Portal:

  View the status of an authorization by visiting www.ascensionpersonalizedcare.com

5. What are Seton Health Plan's prior authorization processing times?
Seton Health Plan is URAC accredited and uses industry standard processing times for prior authorization requests. Routine pre-service requests will be processed within 14 calendar days, standard inpatient concurrent is 24 hours, urgent outpatient within 72 hours, urgent inpatient within 24 hours.

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6. What situation constitutes an “urgent or expedited request”?
Expedited organization determinations are made when the member or their provider believes that waiting for a decision under the standard timeframe could place the member’s life, health or ability to regain maximum function in serious jeopardy.

7. What are the criteria for how prior authorization decisions are made?
Seton Health Plan uses InterQual criteria - an industry-standard tool that applies nationally recognized clinical care guidelines to support the decision-making process. When InterQual criteria is not available for a specific service, evidenced-based resources will be utilized and the medical necessity determination will be made by a physician reviewer.

8. What happens if authorization is not obtained for services that require prior authorization?
All inpatient admissions and services on the prior authorization list require approval prior to the service being obtained. If prior authorization is not obtained prior to the service being rendered, the service may not be approved for payment.