Seton Health Plan
A member of the Seton Healthcare Family

Prior-Authorization Form
Medical Management Dept.
Phone #: (512) 324-3135
Fax #: (512) 380-4253

Referral Type:
□ Routine
□ Urgent (Service in next 72hrs)

* Plan Name ☐ SmartHealth 500 ☐ SmartHealth HDHP 1300	☐ Seton Care Plus ☐ Charity (attach demographic sheet with address/phone number(s), etc) *	☐ MAP ☐ City/County Community Clinic (CCHC/COTHER) TERM DATE:

*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:	

*** In order to process request, all required fields with asterisks must be completed.**

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