Seton Health Plan A member of the Seton Family of Hospitals	Pre-Certification Form Medical Management Dept. Phone #: (512) 324-3135 Fax #: (512) 324-1936	Referral Type: □ Routine □ Urgent (Service in next 72hrs)

* **Plan Name** ☐ **Seton EPN** ☐ **Seton EPN Expanded**	☐ **Seton Care Plus** ☐ **Charity** ☐ **Other:**_____	☐ **MAP** ☐ **City/County Community Clinic (CCHC/COTHER)**

***Request Date:**		***Submitted by (Name):**		***Phone # and Ext:**	

Return Fax #: (include area code if outside Austin):	
***Patient Name:**	

***DOB:**		***Patient's ID Number:**	

Patient's Address:		**City:**		**State:**		**Zip:**	

***Requesting Provider or Clinic name:**			
***Requested Specialist or Service:**		***Req. # of visits:**	
***Diagnosis & ICD-9 Codes:**			
***Description of Procedure & CPT or HCPCS(s) Codes:**		***Proposed Date of Service:**	
* **FACILITY NAME (for Inpatient or Outpatient Services):**			

***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):**

Pre-admission diagnostic work-ups, including lab, imaging and/or supporting specialty consultations:

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:		**Services Approved:**	

Comments/Questions:

*** In order to process request all required fields must be completed**

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