Kelsey-Seybold Clinic
Changing the way health cares.

Authorization Request Form (UR Form)

Outpatient UM Fax #: 713-442-5333
Inpatient UM Fax #: 713-442-4930

Please Send:

1)Pertinent Clinical Progress Notes.
2)Pertinent Lab and Radiological Results.
3)Any other information to support your request.

Please complete all required fields. (*)

UR Phone: 713-442-5339

Urgent reviews: Request an urgent review for a patient with a life-threatening condition, or if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health. Please provide justification that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function in the Urgent box below.

Priority*:
☐ **Routine**
☐ **Urgent –** Please include a Clinical Reason for Urgency:

Request Type*:
☐ **Inpatient (Concurrent)**
☐ **Outpatient/Inpatient Preservice**
☐ **Inpatient Retro**

Medicare Advantage Plans
☐ KelseyCare Advantage
☐ WellCare Texan Plus
☐ Aetna HMO MA

Kelsey-Seybold Capitated EPO, HMO and POS, IPA & Commercial Plans:
☐ CIGNA HMO Network; POS Network
☐ Cigna SureFit
☐ Blue Essentials ERS HealthSelect of Texas
☐ TRS Blue Essentials HMO
☐ KelseyCare Powered by CIGNA – Network
☐ KelseyCare Powered by CIGNA – Network POS
☐ KelseyCare Aetna
☐ Aetna Marketplace Gold, Silver
☐ UHC IFP

Patient Name (last, first)*:	
Patient Date of Birth*:	
Patient Member ID*:	
Name of Nurse/ Staff submitting form*:	
Submitter's Phone*:	
Submitter's Fax*:	
Today's Date*:	

Requesting (Referred By) Provider or Facility*		Service (Referred To) Provider*	Authorization Type:
Name:		Name:	☐ Ambulance Transport
NPI#	Specialty:	NPI:	☐ Consultation/Follow-Up
Phone:	Fax:	Specialty:	☐ Dialysis
Group Name:	Address:	Location/Address:	☐ DME
Requesting Provider's Signature and Date*:			☐ Home Health
			☐ Outpatient Diagnostic Radiology
			☐ Outpatient Labs
			☐ Outpatient Surgery
		Phone:	☐ Outpatient Therapy (PT/OT/ST)
		Fax:	☐ Inpatient - Direct Admit
		Group Name:	☐ Inpatient Surgery
			☐ 23 Hour Observation
			☐ ER Admission to Inpatient
			☐ IPR
			☐ SNF
			☐ LTAC
			☐ Transplant Evaluation
			☐ Transplant Surgery
			☐ Other:

Service (Referred To) Facility*	Date of Service*:
Name:	Authorization Start/End Dates*:
NPI:	
TIN:	
Location/Address:	Diagnosis/ICD-10 Code*:
	CPT/HCPCS Code (and Qty) *:
	Other pertinent information to be considered: