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 HMO
☐ ERS HealthSelect of Texas HMO (Blue Essentials)
☐ TRS Care HMO (Blue Essentials)
☐ KelseyCare Powered by CIGNA – Network
☐ KelseyCare Powered by CIGNA – Network POS
☐ KelseyCare Aetna
☐ UHC Marketplace

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*:	

Referred by Provider or Facility*	
Name:	TIN:
NPI:	Specialty:
Phone:	Fax:
Group Name:	Address:

Requesting Provider's Signature and Date*:

Referred to Provider*	
Name:	
NPI:	TIN:
Specialty:	
Location/Address:	
Phone:	
Fax:	
Group Name:	

Authorization Type:
☐ Ambulance Transport
☐ Consultation/Follow-Up
☐ Dialysis
☐ DME
☐ Home Health
☐ Outpatient Diagnostic Radiology
☐ Outpatient Labs
☐ Outpatient Surgery
☐ Outpatient Therapy (PT/OT/ST)
☐ Inpatient - Direct Admit
☐ Inpatient Surgery
☐ 23 Hour Observation
☐ ER Admission to Inpatient
☐ IPR
☐ SNF
☐ LTAC
☐ Transplant Evaluation
☐ Transplant Surgery
☐ Other:

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: