Authorization Request Form

Want faster service? Use our Provider Portal at https://kelseycarelink.com/

Please fax completed form to appropriate number.
Outpatient UM Fax #: 713-442-5333 | Inpatient UM Fax #: 713-442-4930

Kelsey Seybold Clinic®
Changing the way health cares.®

Complete all required fields (*) and submit all applicable supporting clinical documentation (e.g., office notes, history and physical, diagnostic results, treatment plans, signed orders, or other records supporting medical necessity). Incomplete requests may result in processing delays or dismissal, as applicable. Requests for expedited (urgent) review must include clinical documentation demonstrating why applying the standard review timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function. Notification is required for any date-of-service change.

For authorization status or to receive appeals information, call 713-442-5440. For general UR questions, call 713-442-5339.

Requestor Information			
Requestor's Name*:	Fax*:	Phone*:	Today's Date:

Patient Information			
Patient ID*:	First Name*:	Last Name*:	DOB*:

Request Priority (choose one)*

Urgent reviews: Request an urgent review when a member has a life-threatening condition or when the provider believes the condition is severe enough that waiting for a standard review could seriously worsen the member's health or ability to recover. When submitting an urgent review request, please explain in the **Urgent** section below why the standard review timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function.

☐ Routine ☐ Urgent **Clinical Reason for Urgency (required):** _____

Plan Selection (choose one)*

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 (BCBSTX)
☐ TRS Care HMO (Blue Essentials) ☐ KelseyCare Powered by CIGNA – Network ☐ KelseyCare Powered by CIGNA – Network POS
☐ KelseyCare Aetna ☐ UHC Marketplace ☐ Allegiance TPA/Humble ISD

Requesting Provider (please print)			
Specialty:	NPI/Tax ID*:		
Provider Name*:	Fax*:	Phone:	
Address:	City:	State:	Zip Code:

Servicing/Dispensing Provider or Facility (please print)			
Specialty:	Plan to Assign:	NPI/Tax ID*:	
Provider/Facility Name*:	Fax*:	Phone:	
Address:	City:	State:	Zip Code:

Diagnosis Codes*		
ICD-10:	**ICD-10:**	**ICD-10:**
ICD-10:	**ICD-10:**	**ICD-10:**

Inpatient Services

Authorization Request Type (choose one)
☐ ER Admission to Inpatient ☐ Inpatient (Admission) ☐ Inpatient (Surgery) ☐ Inpatient (Concurrent) ☐ Inpatient (Rehab)
☐ Inpatient (Retro) ☐ LTAC ☐ SNF ☐ Surgery ☐ Transplant (Surgery)
☐ 23-Hour Observation ☐ Other: _____

Place of Service (check one):	☐ ALF (13) ☐ Observation Hospital (22) ☐ Inpatient (21) ☐ Ambulatory Surgery Center (24) ☐ SNF (31) ☐ Nursing Facility (32) ☐ Other (please specify) _____

Date of Admission*:	Is this a Level of Care Change (OBS to INP)?: ☐ Yes ☐ No Observation Admit Date:
Planned/Anticipated Surgery Date*:	Requested length of stay: _____ days

Procedure Code(s)	Description
CPT/HCPCS Code:	
CPT/HCPCS Code:	
CPT/HCPCS Code:	
CPT/HCPCS Code:	
CPT/HCPCS Code:	
CPT/HCPCS Code:	

Outpatient Services

Authorization Request Type (choose one)

☐ Ambulance Transport ☐ Consultation/Follow-Up ☐ Dialysis ☐ DME ☐ Home Health (Initial)
☐ Home Health (Recertification) ☐ Outpatient (Diagnostic Radiology) ☐ Outpatient (Labs) ☐ Outpatient (Surgery)
☐ Outpatient (Skilled Services | OT/PT/ST/Other) ☐ Transplant (Evaluation) ☐ Other: _____

Place of Service (check one): ☐ Telehealth (02) ☐ Office (11) ☐ Outpatient Hospital (22) ☐ Dialysis Center (65) ☐ Lab (81) ☐ Home (12) ☐ SNF (31) ☐ Other (please specify) _____

Anticipated Service Date*:

Service Requested*	Procedure	Start Date	End Date	Frequency
Skilled Nursing				____days a week for ____weeks= ____visits
Home Health Aide				____days a week for ____weeks= ____visits
MSW (Social Worker)				____days a week for ____weeks= ____visits
Physical Therapy				____days a week for ____weeks= ____visits
Occupational Therapy				____days a week for ____weeks= ____visits
Speech Therapy				____days a week for ____weeks= ____visits
Episode of Care (Medicare Only)				____days a week for ____weeks= ____visits

For Home Health Services, a Signed Plan of Care/Order is Required with your Authorization Request!

Date of last therapy evaluation or reevaluation	PT:	OT:	ST:

Attach a copy of the therapy evaluation/reevaluation or progress summary (acute) for each therapy discipline requested.

Please submit separate request for prosthetics vs. orthotics and purchases vs. rentals

☐ Prosthetics ☐ Orthotics
☐ Other (please specify) _____

Is this item needed for discharge? ☐ Yes ☐ No
Discharge Date: _____

☐ Purchase ☐ Rental _____ Months

Has this item been dispensed?* ☐ Yes ☐ No
Dispensed Date: _____

Procedure Code(s)*	Description	Qty	Additional Information
CPT/HCPCS Code:			
CPT/HCPCS Code:			
CPT/HCPCS Code:			
CPT/HCPCS Code:			
CPT/HCPCS Code:			
CPT/HCPCS Code:			
CPT/HCPCS Code:			
CPT/HCPCS Code:			
CPT/HCPCS Code:			
CPT/HCPCS Code:			

If additional codes are needed, please add a supplemental page with additional codes.