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**
- ☐ **Concurrent**
- ☐ **Clinical Update**
- ☐ **Retro**
- ☐ **Urgent –** Please include a Clinical Reason for Urgency:

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
- ☐ KelseyCare Humana
- ☐ 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 Provider or Facility*

Name:	
NPI#	Specialty:
Phone:	Fax:
Group Name: Address:	

Requesting Provider's Signature and Date*:

Request Type:	
☐ Ambulance Transport	**Date of Service*:**
☐ Consultation/Follow-Up	**Authorization Start/End Dates*:**
☐ Dialysis	
☐ DME	**Diagnosis/ICD-10 Code*:**
☐ Home Health	
☐ Outpatient Diagnostic Radiology	
☐ Outpatient Labs	
☐ Outpatient Surgery	**CPT/HCPCS Code (and Qty) *:**
☐ Outpatient Therapy (PT/OT/ST)	
☐ Inpatient	
☐ Inpatient Surgery	
☐ 23 Hour Observation	**Other pertinent information to be considered:**
☐ IPR	
☐ SNF	

Service Provider*

Name:
NPI:
Specialty:
Location/Address:
Phone:
Fax:
Group Name:

Service Facility*

- ☐ Clear Lake Regional
- ☐ Gramercy
- ☐ Houston Northeast Medical Center
- ☐ Kingwood Medical Center
- ☐ Kelsey-Seybold Clinic ASC
- ☐ Kelsey-Seybold LabCorp
- ☐ MD Anderson Cancer Center
- ☐ Memorial Hermann: (add location)
- ☐ Houston Methodist (add location):
- ☐ CHI St. Luke's Hospital (add location):
- ☐ CHI St. Luke's Hospital – Medical Ctr
- ☐ CHI St. Luke's Brazosport Facility
- ☐ CHI St. Luke's Kirby Glen
- ☐ CHI St. Luke's Medical Towers
- ☐ Texas Children's Hospital
- ☐ TCH Woman's Pavilion
- ☐ Tomball Regional Medical Center
- ☐ Women's Hospital of Texas

☐ LTAC		☐ HCA Facility:
☐ Transplant Evaluation		☐ Other:
☐ Transplant Surgery		
☐ Other:		
		Huntsville Clinic PCP*
		☐ Yes
		☐ No