



**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 <input type="checkbox"/> Seton EPN <input type="checkbox"/> Seton EPN Expanded		<input type="checkbox"/> Seton Care Plus <input type="checkbox"/> Charity <input type="checkbox"/> Other: _____		<input type="checkbox"/> MAP <input type="checkbox"/> City/County Community Clinic (CCHC/COTHER)	
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*Request Date:		*Submitted by (Name):		*Phone # and Ext:	
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Return Fax #: (include area code if outside Austin):	
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*Patient Name:	
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*DOB:		*Patient's ID Number:	
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Patient's Address:		City:		State:		Zip:	
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*Requesting Provider or Clinic name:	
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*Requested Specialist or Service:		*Req. # of visits:	
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*Diagnosis & ICD-9 Codes:	
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*Description of Procedure & CPT or HCPCS(s) Codes:		*Proposed Date of Service:	
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* FACILITY NAME (for Inpatient or Outpatient Services):	
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*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):	
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Pre-admission diagnostic work-ups, including lab, imaging and/or supporting specialty consultations:	
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**Coordination of Benefits (Other Insurance)**

*Workman's Compensation:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	*MVA Subrogation :	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Date of Injury:	
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*Other Insurance Coverage	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Name of Insurance:		Subscriber Name and ID #	
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**TO BE COMPLETED BY SETON HEALTH PLAN MEDICAL MANAGEMENT SERVICES**

Authorization Number:		Authorization Dates:	
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Number of Visits:		Services Approved:	
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Comments/Questions:	
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**\* In order to process request all required fields must be completed**

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