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
☐ Humana HMO MA
☐ Humana MA D-SNP

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 Bronze, Gold, Silver
☐ AmeriBen TPA (Academy)
☐ Centerwell

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 (if applicable):	

Requesting Provider's Signature and Date*:

Request Type:
☐ Ambulance Transport
☐ Consultation/Follow-Up
☐ Dialysis
☐ DME
☐ Home Health
☐ Outpatient Diagnostic Radiology
☐ Outpatient Labs
☐ Outpatient Surgery
☐ Outpatient Therapy (PT/OT/ST)
☐ Inpatient
☐ Inpatient Surgery
☐ 23 Hour Observation
☐ IPR
☐ SNF

Date of Service*:

Authorization Start/End Dates*:

Diagnosis/ICD-10 Code*:

CPT/HCPCS Code (and Qty) *:

Other pertinent information to be considered:

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:		