

 <p><b>Seton Health Plan CHIP</b></p> <p><small>A member of the Seton Healthcare Family</small></p>	<p><b>Seton Health Plan CHIP/STAR</b></p> <p>Phone Number (512) 420-2777 or 1-877-451-5628  FAX Number (512) 420-2798 or toll free (866) 272-2542</p> <p>Referral Type: <input type="checkbox"/> ROUTINE  <input type="checkbox"/> URGENT (Service in next 72hrs)</p>	 <p><b>Seton Health Plan STAR</b></p> <p><small>A member of the Seton Healthcare Family</small></p>
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* Plan Name :	<input type="checkbox"/> Seton CHIP <input type="checkbox"/> Seton STAR
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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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*Requesting Provider or Clinic name:	
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*Requested Specialist or Service:	*Req. # of visits:	
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*Diagnosis & ICD-10 Codes:	
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*Description of Procedure CPT or HCPCS Codes:		<input type="checkbox"/> IP <input type="checkbox"/> OP <input type="checkbox"/> OBS
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LMP:		EDC:	
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* FACILITY NAME (for Inpatient or Outpatient Services):		*Proposed Date of Service:	
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<p>*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):</p>
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<p>Pre-admission diagnostic work-ups, including lab, imaging and/or supporting specialty consultations:</p>
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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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<p>Comments/Questions:</p>
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**\* In order to process request all required fields must be completed**

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