

Please be aware that you may submit all prior authorization requests, view authorization status and authorization determination letters via our interactive provider portal (24/7 - 365 days/year).

For questions about utilization review or prior authorization process, please contact Ascension Insurance Utilization Management Gateway at: 1-844-217-8191.

Request Date: ___/___/___
Review Type: [] Service not available
[] Appointment availability

MEMBER INFORMATION

Member Name: Last, First, Middle (please PRINT)
Address:
Date of Birth: ___ / ___ / ___
Member ID #:
Phone #:
Birth Sex: [] Male [] Female [] Unknown
Age:
Please enter Admission / Start date of Service: ___ / ___ / ___

REQUESTOR CONTACT INFORMATION

ASCENSION NETWORK REFERRING PHYSICIAN / PROVIDER

Requestor's Name:
Phone #:
Fax #:
Place of Service: [] Home [] Inpatient [] Outpatient
[] Physician Office [] Other
Severity: [] Standard (non-urgent) [] Expedited/Urgent
[] Other
By checking the Expedited/Urgent box, you attest that applying the standard review timeframes may seriously jeopardize the member's life, health or ability to regain maximum function, or subject the member to severe pain that cannot be adequately managed.
Name: Last, First, Middle
Address:
Specialty:
Phone #:
Fax #:
TIN #: (Required)
NPI #:



FACILITY/PROVIDER INFORMATION	PROCEDURE
Facility: _____ Address: _____ _____ _____ Phone #: _____ Fax #: _____ TIN #: _____ (Required)	Primary Diagnosis: _____ Primary Diagnosis Code: _____ Procedure Code: _____ Description: _____ Start Date: ____ / ____ / ____ End Date: ____ / ____ / ____ Units: _____ <input type="checkbox"/> Days <input type="checkbox"/> Units <input type="checkbox"/> Visits (check one)
Clinical Summary Information- prior treatment history, current treatment plan and other pertinent information, etc.	

SUPPORTING DOCUMENTATION

Only submit clinical information that supports the referral request for service(s) to determine medical necessity or specifically requested by Ascension Insurance Utilization Management Gateway.

Type of Review Request	Documentation
All Types of Referral Requests	Documentation not included in the referral request form that supports the medically necessity of the requested services.
Urgent Review Requests	Requests can only be submitted as urgent <i>if applying the standard review time frames may seriously jeopardize the member's life, health or ability to regain maximum function, or subject the member to severe pain that cannot be adequately managed.</i>

Disclaimer Statement

Ascension Insurance Utilization Management Gateway certification determination does not guarantee payment for services. Eligibility for and payment of services are subject to all terms and conditions and limitations of the Summary Plan Description.

Requesting Provider Attestation Statement

I hereby attest that, as a healthcare services provider or provider's representative, an order for the above medical services has been received for the identified member. In addition, I attest that the treatment plan has been approved by the prescribing (ordering) physician.

Printed Name: _____

Signature: _____

Date: _____

UR/Referral Contact:
 Call 1-844-217-8191
 Effective: 01/01/2024 v1