Central Health / Community Care Collaborative — A Central Health and Seton partnership	**Prior-Authorization Form** MediView Medical Management Dept. Phone: (512) 420-2777 Toll Free Fax: (866) 272-2542 Local Fax: (512) 406-6244	**Referral Type:** □ Routine □ Urgent (Service in next 72hrs)

*** Plan Name**

☐ **Medical Access Program (MAP)** **TERM DATE:______________**
☐ **MAP BASIC** **TERM DATE:______________**
☐ **MAP BASIC Dental-only** **TERM DATE: ______________**

***Request Date:**	***Submitted by (Name):**	
***Phone # and Ext (Include area code):**	***Return Fax # (include area code):**	
***Patient Name:**		
***DOB:**	***Patient's ID Number:**	***Group ID Number:**
***Requesting Provider or Clinic name:**		**NPI:**
***Requested Specialist or Service:**		**NPI:**
***Requested # of visits:**	***Proposed Date of Service:**	
***ICD-10 Codes:**	***Diagnosis Description:**	
***CPT or HCPCS Codes:**	***Description:**	
***Facility Name (for Outpatient Services/ASCs):**		**NPI:**

***** □ **Outpatient** □ **In Office** □ **DME** □ **Therapy**

***Reason for referral (please attach pertinent clinical/progress notes or provide clinical narrative, including duration of problem, types of treatment, physical findings, testing results):**

Coordination of Benefits (Other Insurance)

***Workman's Compensation:**	☐ **YES**	☐ **NO**	***MVA Subrogation:**	☐ **YES**	☐ **NO**	**Date of Injury:**	
***Other Insurance Coverage:**	☐ **YES**	☐ **NO**	**Name of Insurance:**			**Subscriber Name and ID #:**	

TO BE COMPLETED BY MEDIVEW MEDICAL MANAGEMENT SERVICES

Authorization Number:	**Authorization Dates:**
Number of Visits or Services Approved:	
Comments/Questions:	

*** In order to process request, all required fields with asterisks must be completed.**

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