

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

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Issuer Name: Gibbs, Gonzalez and Finley	Phone: +15788887536	Fax: +13262961433	Date: 08/12/2021
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SECTION II — GENERAL INFORMATION

Review Type: <input checked="" type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency: JXGVqXPeGNQFLEWqyItNWJfPv
Request Type: <input checked="" type="checkbox"/> Initial Request <input type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #: 0-599-65681-6

SECTION III — PATIENT INFORMATION

Name: Linda Ortiz	Phone: +12239853999	DOB: 02/21/1957	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Subscriber Name (if different): Joshua Willis	Member or Medicaid ID #: 6487018291	Group #: 978-0-514-33819-6	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Ltoen Klak, MD		Name: Calk Banks, NP	
NPI #: 8989641566	Specialty: OBGYN	NPI #: 2371877675	Specialty: Pathology
Phone: +13510080449	Fax: +13680799831	Phone: +13387970154	Fax: +15669146342
Contact Name: Stooj Blake, RN	Phone: +13219745333	Primary Care Provider Name (see instructions): Carter, Contreras and Hill	
Requesting Provider's Signature and Date (if required): 03/03/2021		Phone: +19192897061	Fax: +13806966552

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version__)	Code
Place po breast cath for rad - 19296		04/22/2006	07/29/2006	Relapsing polychondritis - M94.1	
X-ray exam knee 4 or more - 73564		07/28/2010	09/27/2010	Maternal care for signs of fetal hy - O36.3	
GI protein loss exam - 78282		05/27/2008	11/19/2008	Other bursitis of elbow - M70.3	
Cath place cardio brachytx - 92974		06/12/1997	08/02/1997	Other rosacea - L71.8	

☐ Inpatient ☐ Outpatient ☒ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☒ Mental Health/Substance Abuse
 Number of Sessions: 19 Duration: 60 minutes Frequency: daily Other: shBLWQfzZcrjKchsztxy

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)
 Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

☒ DME (MD Signed Order Attached? ☒ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☒ Yes ☐ No)
 Equipment/Supplies (include any HCPCS Codes): E0570 - Nebulizer with compressio Duration: 45 minutes

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

KUHylZNZBWZqbIcqMvKluBeHPMxkouCRkkqMZBspyFFtdACWEluBxVoeFjDusauEXFdHpODIKPiNEKckmGWHiS
 ElCjJrpHIftMciasiuZvOyNJLWlaWdtJBiamCavMomKQEZsktpjHXJYnCcDPIcecyQpVyfmLaRcjyKkCGccWryPkzgEgDO
 wowKnatcArumLsaLIPiy

An issuer needing more information may call the requesting provider directly at: +13219745333