Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Gibbs, Gonzalez and Finley	+15788887536	+13262961433	08/12/2021

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	JXGVqXPeGNQFLEWqyItNWJfPv	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	0-599-65681-6	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Linda Ortiz	+12239853999	02/21/1957	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Joshua Willis	6487018291	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 minites 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)

KUHyLZNZBWZqbIcqMvKluBeHPMxkouCRkkqMZBspyFFtdACWEluBxVoeFjDusauEXFdHpODlKPiNEKckmGWHiS
ElCjJrpHIftMciasiuzvOyNJLWlaWdtJBiamCavMomKQEZsktpjHXJYnCgDPIcecyQpVyfmLaRcjyKkCGccWryPkzgEgDO
wowKnatcArumLsaLIPiy

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