Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Tucker LLC	+19511113778	+18351315795	05/06/2002

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	ADdIuQQGNkNnKkjOruyLzOYkG	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-8451-2373-4	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Tiffany Morgan	+10418728116	01/19/1999	

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
John Davis	51834642117	978-0-560-66678-6

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Inda Laec, PA		Name: Pilot Kala, RN	
NPI #: 5649341700	Specialty: Physical Medicine	NPI #: 6098336630	Specialty: Neurology
Phone: +15332220344	Fax: +12141675143	Phone: +14088976680	Fax: +10845187015
Contact Name: Inda Laec, PA	Phone: +16928546413	Primary Care Provider Name (see instructions): Smith PLC	
Requesting Provider's Signature and Date (if required): 08/05/2000		Phone: +19986238190	Fax: +18217713268

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
Lung perf&ventilat diferentl		11/08/2006	07/21/2007	Chondrocostal junction syndrome [Ti -	M94.0
"Chemodenervation of muscle(s); muscle(s) innervated by facial nerve		08/27/1997	06/30/1998	Unspecified appendicitis -	K37
Pt eval high complex 45 min		02/27/2021	10/11/2021	Driver injured in collision with ot -	V29.4
X-ray exam of shoulder		05/08/2019	06/19/2019	Other disorders of brain in disease -	G94

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

☐ Physical Therapy ☐ Occupational Therapy ☑ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions: 25 Duration: 120 minites Frequency: bimonthly Other: hsIvDwaXWCRaIKcpIqmC

☐ 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): _____ Duration: _____

Section VI — Clinical Documentation (See Instructions Page, Section VI)

A X-ray exam of the shoulder is clinically indicated to evaluate the anatomy and pathology of the shoulder joint and surrounding soft tissues. This is

An issuer needing more information may call the requesting provider directly at: +16928546413