Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Jones Group	+16011545630	+15198295081	04/01/2021

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	VtdPbGqSpGOAnbPUQNYhuSFTX	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-637-91429-5	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Taylor Marshall	+18210278067	07/14/1960	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Kathleen Gray	80007589929	978-0-18-143760-4	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Peter Pan, MD		Name: Dr. Peter Pan, MD	
NPI #: 1170390400	Specialty: Immunology	NPI #: 4959680062	Specialty: Otolaryngology
Phone: +12203939836	Fax: +12106532158	Phone: +11217871337	Fax: +10337505055
Contact Name: Dr. A1my Shaw, MD	Phone: +11536918297	Primary Care Provider Name (see instructions): Brown LLC	
Requesting Provider's Signature and Date (if required): 10/09/1999		Phone: +13350540879	Fax: +14746642788

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
Screen pap by tech w md supv - P3000		07/02/2008	08/15/2008	Motorcycle rider [any] injured in o - V29.8	
Tc99m sulfur colloid - A9541		12/19/1995	09/29/1996	Trichotillomania - F63.3	
Fxn gene analysis - 0233U		05/17/2003	09/03/2003	Injury of multiple blood vessels at - S15.7	
Mri lumbar spine w/o & w/dye - 72158		10/21/2002	05/11/2003	Abnormal findings in specimens from - R86.9	

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

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

Number of Sessions: 3 Duration: 45 minutes Frequency: 3 times a week Other: MRFZOdxTeNEqaVXemhBZ

☐ 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)

IMQHWGDEbUfDhWdNXbyCYafFRQrvqjSLWazXRKpMzyrSPvXbWUkROYDjaUpJStaSGnQHvGLxhoBILhdHSN
KxJEJmQAXqLDhVRMsIiGBKZYfuEhMhRfrccYSduVPxkVHFbFBPBKOKxhfNUJCSKNdhpkoNGcvaSjDDPKNEh
ikgJAwbyZzmKqOGhywPCuQnyZpaNShMTGbP

An issuer needing more information may call the requesting provider directly at: +11536918297