Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Saunders-Gomez	+10652402298	+18419038318	03/10/2016

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	ikhSQzVRTBUjnyUQLaJmTUPtd
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	0-312-54738-2

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Female ☑ Other ☐ Unknown
Charles Sparks	+18339305627	10/14/2015	
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	
Andre Brown	92439572347	978-1-5163-1946-6	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Bob Faylor, PA		Name: Ram Stam, MA	
NPI #: 3245791964	Specialty: General Surgery	NPI #: 8823647701	Specialty: Pathology
Phone: +19384409067	Fax: +12679558947	Phone: +18809405317	Fax: +15052186295
Contact Name: Stooj Blake, RN	Phone: +14075708000	Primary Care Provider Name (see instructions): Collins Inc	
Requesting Provider's Signature and Date (if required): 11/12/2018		Phone: +10808290711	Fax: +10040711553

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
Brachytx, non-str, HA, I-125 - C2634		08/25/1995	05/03/1996	Chronic tubulo-interstitial nephrit - N11.9	
CCIIV4 vac no prsv 0.5 ml im - 90674		02/02/2015	09/03/2015	Other specified disorders of urethr - N36.8	
Rp quan meas single area - 78835		12/18/1992	11/14/1993	Aneurysm and dissection of carotid - I72.0	
Bfb training ea addl 15 min - 90913		01/26/2016	05/09/2016	Congenital infectious and parasitic - P37.9	

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

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

Number of Sessions: 19 Duration: 45 minutes Frequency: monthly Other: scIYpzCTQkOyCGyKCMDl

☐ 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)

HUcUJMGEySdLeSakSZbNwgXqIScQHilnoTSyhCzTHGFMiwWjHPsaiAaMMglXAdvkvUojqhKYgJwXEQVydLuKeyHKkNaDbwAUzZQvRfkZxWPIFWzITtKbZTltJajGeAqeSMRRrAkxPgLqanzakibhCHYxRDVXgvpDzEOXPjUgdaDaRLOGIgPWWLUIRspdJpZINocIOjbk

An issuer needing more information may call the requesting provider directly at: +14075708000