Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Anderson PLC	+15533770236	+11483656876	05/11/2002

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	zpaSsFxAZjvBSohAQmPixyeYJ	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-288-04411-8	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Mike Mcintyre	+11899072113	07/23/1970	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Carla Conway	15338610004	978-0-615-44095-8	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Inda Laec, PA		Name: Dr. A1my Shaw, MD	
NPI #: 2614908298	Specialty: Orthopedic Surgery	NPI #: 8707249859	Specialty: OBGYN
Phone: +13560880218	Fax: +14578880111	Phone: +10715439741	Fax: +12385730401
Contact Name: Pilot Kala, RN	Phone: +16017259894	Primary Care Provider Name (see instructions): Myers, Noble and Huffman	
Requesting Provider's Signature and Date (if required): 02/25/1994		Phone: +13282127662	Fax: +15759233025

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
Gastric emptying imag study - 78266		12/25/2009	10/01/2010	Intestinal bypass and anastomosis s - Z98.0	
Hyperthermia treatment - 77615		04/23/2008	07/27/2008	Apocrine sweat disorders - L75	
X-ray exam of pelvis - 72170		05/27/2009	10/24/2009	Postconcussional syndrome - F07.2	
Leukacyte transfusion - 86950		12/14/2008	12/27/2008	Benign neoplasm: Skin of upper limb - D23.6	

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

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

Number of Sessions: 21 Duration: 90 minites Frequency: bimonthly Other: sPliOVQoheGixXyOtpdj

☐ 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)

veoRMyiuNNLDLNXkeIWAtyQmgrwCdWEEQmwvGkADbPxpordkgsxxOljEzsVGOHCxmXrKDdyZnsuzRqMpEcT
HvoacrTDYFCpAMOQsYPWgDxjsQFjZYgrwsxoEAYHUgryUHOGAapSnWbylkfnZcCFoegILtJGhZtoNhMUhKRPcJ
QdlrqDqMkENmJklvNnBKjabivLKMVNd

An issuer needing more information may call the requesting provider directly at: +16017259894