Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Wilson, King and Berg	+16326653674	+11295565877	10/13/1998

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	yZAgLtVtOKWYzKcIeQAyGWQTG	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	0-254-08143-6	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Cynthia Zhang	+13181116807	12/31/1967	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Stephanie Houston	96202346000	978-1-908991-65-2	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Bob Faylor, PA		Name: Dr. Ltoen Klak, MD	
NPI #: 5550176330	Specialty: Physical Medicine	NPI #: 5851155194	Specialty: OBGYN
Phone: +11664274225	Fax: +17529704681	Phone: +12632566808	Fax: +17474809292
Contact Name: Dr. Ltoen Klak, MD	Phone: +16557698523	Primary Care Provider Name (see instructions): Morris, Kelly and Hutchinson	
Requesting Provider's Signature and Date (if required): 12/05/2020		Phone: +19862718587	Fax: +10688156169

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
Hyperthermia treatment - 77610		10/31/2019	08/10/2020	Intentional self-harm by jumping or - X81	
Assay bld/serum cholesterol [only w - 82465		07/27/1996	07/17/1997	Human immunodeficiency virus [HIV] - B20-B24	
X-ray head for orthodontia - 70350		02/17/2021	12/15/2021	Congenital rectovaginal fistula - Q52.2	
Ct uppr extremity w/o&w/dye - 73202		01/16/1999	10/20/1999	Crushing injury of other parts of f - S57.8	

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

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

Number of Sessions: 20 Duration: 45 minutes Frequency: 2 times a month Other: zSPUVIPbKhkjKqRJbTiZ

☐ 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): E0486 - Oral device/appliance use Duration: 60 minites

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

vzVmbDdayvodIErjDjxbcdBcBOrdsVdkPjwzfiLqgMtDbXysELSjcswUBsaWECKrIbEEyTJSLaxEexWgneJVGeaJWr
McnHMKoCTyqpWJxZORUQvHtCQrxBPDSNYjITBfrTRdotnPEVQAOHGPLOJsqpxKQVbzBSHzYNEgOGWOsHk
RhzAHCWivMHcawZQLicukFJHyVvrR

An issuer needing more information may call the requesting provider directly at: +16557698523