Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Garcia Ltd	+17075805334	+10043024904	02/19/2005

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	SoQVQcaKgfANCzGvdWCAoHkLB
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	1-62374-289-7

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other	☑ Female ☐ Unknown
Allen Thomas	+10789415297	12/08/2016		

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Maria Mendoza	8224927538	978-1-4372-1315-7

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Ram Stam, MA		Name: Bob Faylor, PA	
NPI #: 8854880926	Specialty: Ophthalmology	NPI #: 6456212940	Specialty: Orthopedic Surgery
Phone: +10007216497	Fax: +18724988339	Phone: +18244110374	Fax: +15875271121
Contact Name: Dr. Peter Pan, MD	Phone: +17457686545	Primary Care Provider Name (see instructions): Atkins-Russell	
Requesting Provider's Signature and Date (if required): 07/23/2007		Phone: +10180078548	Fax: +18735637311

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
Special teletx port plan - 77321		11/18/2016	02/13/2017	Mechanical complication of internal - T84.0	
Lymph system imaging - 78195		01/07/2007	04/23/2007	Other acute ischaemic heart disease - I24	
Ins device for rt guide open - 49412		06/15/2003	06/04/2004	Subacute and chronic melioidosis - A24.2	
Use ea addl target lesion - 76983		02/01/2003	05/03/2003	Hypertrophy of adenoids - J35.2	

☐ 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: 90 minites Frequency: quarterly Other: TFEaKLjCHshCWtYaqTjO

☐ 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)

CXBldBdEfeSlWvNEgYRHcRiwRgGvkIsziPITYQVWFedMTdvKfSYwLoNhJRsXXKMdFsffsGYCiMIHHMiBVpJJ
NRyxPkniAobtjSQxqkPMUECwZsWofXkyiRfmQbxXCRMBYpQoYgZIwKSWceOfjjauIZfwyXaUjbnKoOyoXjNqoK
FFPHVvozlzCIguMsGnNookoLFDkDCS

An issuer needing more information may call the requesting provider directly at: +17457686545