Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Fleming-Wallace	+14913802640	+10271199929	10/29/1993

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	vefQuJWczqvWOVuhbOzpydwcd	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	1-243-61141-3	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Jennifer Heath	+17333175761	08/16/2006	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Jane Rodriguez	47750963635	978-0-13-659714-8	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Peter Pan, MD		Name: Dr. Ltoen Klak, MD	
NPI #: 8215992136	Specialty: Diagnostic Radiology	NPI #: 751000631	Specialty: Clinical Pathology
Phone: +13532216631	Fax: +12322657092	Phone: +13428913006	Fax: +11116572614
Contact Name: Inda Laec, PA	Phone: +16006811078	Primary Care Provider Name (see instructions): Martin, Waller and Richardson	
Requesting Provider's Signature and Date (if required): 07/01/2021		Phone: +12251994598	Fax: +14960102756

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
Ct hrt w/3d image - 75572		08/18/2021	08/22/2021	Obstetric embolism - O88	
X-ray exam sacroiliac joints - 72202		08/05/1996	03/14/1997	Lichen nitidus - L44.1	
RMVL devital tis 20cm/< - 97597		07/08/2015	10/13/2015	Injury of other nerves at lower leg - S84.8	
Jak2 gene trgt seq alys - 0027U		09/09/2006	09/13/2006	Other streptococcal sepsis - A40.8	

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

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

Number of Sessions: 5 Duration: 60 minites Frequency: monthly Other: UAqvxPiqAqKHgEBUjdlt

☐ 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)

scTMOZZafnjBAEfKlcyhPSEfIKLaNbBFndgrIUtCspQNweAUvkzYFxQoKzgSKRUAcqMAhbshYTACKESGNOZFosB
OHDkSLGTiffEBQeDWJZcfgTldgkVYKllTpXfYjXNpSFpVkHNEgRpEjgBMARVbATDdWNfKZVvwEqNfwuBuDoZYo
qLaWjRIxZGFfplMLdLPFsqlzvkH

An issuer needing more information may call the requesting provider directly at: +16006811078