Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Newman, Floyd and Martin	+15338477063	+13726026331	07/08/2005

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	JbpPpSTVOzInbBnSpOothzOPY	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-18-951895-2	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Ruth Lee	+15434904654	01/12/1925	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Kristin Lucas	55141639238	978-1-263-05700-0	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Peter Pan, MD		Name: Stooj Blake, RN	
NPI #: 8055363454	Specialty: Dermatology	NPI #: 9552297387	Specialty: Nuclear Medicine
Phone: +17231133388	Fax: +12162165793	Phone: +16821223401	Fax: +11365681430
Contact Name: Dr. Amy Shaw, MD	Phone: +15718332446	Primary Care Provider Name (see instructions): Avery and Sons	
Requesting Provider's Signature and Date (if required): 10/31/2020		Phone: +16026353456	Fax: +14488108847

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
Mri lumbar spine w/dye - 72149		01/28/2013	09/20/2013	Malignant neoplasm of gallbladder - C23	
Radiation treatment delivery - 77402		06/06/2012	03/21/2013	Abnormal findings in specimens from - R86.0	
"Repair of blepharoptosis; frontal - 67901		07/29/2015	04/18/2016	Drugs, medicaments and biological s - Y40-Y59	
GI nuclear procedure - 78299		01/05/2013	01/31/2013	Sickle-cell anaemia without crisis - D57.1	

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

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

Number of Sessions: 23 Duration: 120 minites Frequency: 2 times a month Other: KRKBIXjwnYdBeaTfKGhv

☐ 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)

lMFdUVKszKCWiGKnWobfIEKoazbShSeILrbaRAJJwBmHdFvTfDgmzNvVkbNZEbtiFlJzuyQIapeswRYRTFlMGOCUke
YEpkyiNnQPcmCnKKwgEXaxVcBvgAhZZKwonETDRbWbcqzhzhAXBRWLgUkISughhjxXpiouVgtdkePaLGORkCESm
iBbwyirWuIEikpzQJnTKBGC

An issuer needing more information may call the requesting provider directly at: +15718332446