Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Lewis-Nguyen	19775254110	11123882285	06/07/2017

Section II — General Information

Review Type: ☑ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	ejxzhOuXCzJpajJSJrVjgEnGR	
Request Type: ☑ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	1-369-09996-7	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☑ Female ☑ Other ☑ Unknown
Bridget Miller	19551166144	10/23/1984	

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Katrina Dominguez	60956466555	978-1-74516-827-9

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Ltoen Klak, MD		Name: Inda Laec, PA	
NPI #: 2517932737	Specialty: Anesthesiology	NPI #: 3863823350	Specialty: Neurological Surgery
Phone: 11227141945	Fax: 14801745962	Phone: 10672096568	Fax: 12441600016
Contact Name: Inda Laec, PA	Phone: 15590875408	Primary Care Provider Name (see instructions): Griffin, Fields and Warren	
Requesting Provider's Signature and Date (if required): 06/08/2015		Phone: 13912124526	Fax: 13415475319

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
Cad cxr remote - 0175T		07/30/2021	01/01/2022	Contusion of thorax - S20.2	
Vol reduction of blood/prod - 86960		08/13/2002	12/20/2002	Benign lipomatous neoplasm of skin - D17.2	
Radiation treatment delivery - G6009		02/11/2016	10/10/2016	Other histiocytosis syndromes - D76.3	
Use 1st target lesion - 76982		08/05/1997	09/07/1997	Other pulmonary valve disorders - I37.8	

☑ Inpatient ☑ Outpatient ☑ Provider Office ☑ Observation ☑ Home ☑ Day Surgery ☑ Other: other

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

Number of Sessions: 7 Duration: 10 days Frequency: yearly Other: VZTibyGCfmEGYVRRkLaS

☑ Home Health (MD Signed Order Attached? ☑ Yes ☑ No) (Nursing Assessment Attached? ☑ Yes ☑ No)

Number of Visits: 12 Duration: 15 min. Frequency: weekly Other: other

☑ DME (MD Signed Order Attached? ☑ Yes ☑ No) (Medicaid Only: Title 19 Certification Attached? ☑ Yes ☑ No)

Equipment/Supplies (include any HCPCS Codes): bath stool Duration: 12 weeks

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

xnHEhAtmFWDJGvibpkAgCyxenHMKoOgFXFJMlbxpOPEZRPurxsngRyMDtQgsMasSaWDamXeswcaofEeAgfQacr
ERqjgATmhxrnbxxwAuLqkBqyWGALFAOkTvqmsbwQdzNjSFxKwpxzaxqNxMavILTuyqiAYbhgWrqnWkoZRpUuzc
jLsuqppVQrdyAWMbqMhFUnJHznqh

An issuer needing more information may call the requesting provider directly at: 15590875408