Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Nguyen LLC	+17664592197	+18400508796	03/09/2020

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	gYNVEGZoihTBPRxFWyrRKmiel	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-7014-6848-3	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Gwendolyn Bell	+19968360363	08/13/1952	

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
David White	22890588607	978-1-321-86477-9

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Peter Pan, MD		Name: Stooj Blake, RN	
NPI #: 5437962023	Specialty: Emergency Medicine	NPI #: 6155027479	Specialty: Anatomic
Phone: +14759224994	Fax: +18608098694	Phone: +12216760512	Fax: +10974601535
Contact Name: Dr. Peter Pan, MD	Phone: +12177262997	Primary Care Provider Name (see instructions): Graves Group	
Requesting Provider's Signature and Date (if required): 11/19/2002		Phone: +19552648854	Fax: +16000726765

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
Extracranial study - 93880		04/30/1997	01/31/1998	Disorders of vitreous body - H43	
Wound(s) care non-selective - 97602		11/04/2013	04/19/2014	Other specified drowning and submer - W73	
P32 chromic phosphate - A9564		11/14/2016	09/14/2017	Fetus and newborn affected by mater - P04.2	
Semen analysis - G0027		11/12/1999	02/04/2000	Lichen nitidus - L44.1	

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

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

Number of Sessions: 11 Duration: 60 minites Frequency: quarterly Other: trPuXssdbtmoKJjZUFjj

☐ 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)

pjSYiJipkIhJDaVtyALwxJNZwbsRmTOIPzbCbCiwdgYGIsMZXkunytlJgtvtmdttFOcfjQWhsnNTkVhEPyhCVRTSrkexvxk
OHyqthanZhAzqpItzjBKZAUYBswYZbKNBJpkfyKOIgGLUQqeDFzinsfonygfYvqFhRChDNbqheovNhxPPXBmIhqpJBb
MAjSYScQSxiTle

An issuer needing more information may call the requesting provider directly at: +12177262997