Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Adams-Austin	+12181019429	+17288435647	11/25/2005

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	eOMVTrRVRlYpddcipdFJXuRnW	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	1-5135-3037-2	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other	☑ Female ☐ Unknown
Raymond Marsh	+11818759007	07/11/1977		

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Charles Perez	9068501072	978-0-601-12499-2

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Bob Faylor, PA		Name: Bob Faylor, PA	
NPI #: 6281174396	Specialty: Psychiatry	NPI #: 6156475642	Specialty: Dermatology
Phone: +19282292204	Fax: +17795025432	Phone: +16341924438	Fax: +13242037687
Contact Name: Inda Laec, PA	Phone: +10814680002	Primary Care Provider Name (see instructions): Rice, Pacheco and Baker	
Requesting Provider's Signature and Date (if required): 04/16/2004		Phone: +13653331591	Fax: +13361449028

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 colonography dx w/dye - 74262		10/24/2021	02/08/2022	Flatulence and related conditions - R14	
Brachytx, NS, Non-HDRIr-192 - C1719		05/09/1996	06/04/1996	Apocrine sweat disorder, unspecifie - L75.9	
Doppler echo exam heart [if used in - 93320		01/21/1995	01/29/1995	Corneal neovascularization - H16.4	
"Injection - J0587		10/07/2005	04/11/2006	Assault by smoke, fire and flames - X97	

☐ 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: 45 minutes Frequency: daily Other: jThJYSLkcbThKruWtlcU

☐ 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): E0570 - Nebulizer with compressio Duration: 30 minutes

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

qLqAWUtbMRogeIkqhzjZSKLNFTHHBJsmDeRGnSKGTTufNOSFlFeDRwENLesuBkeQQCWuJHUYcWvKmexiMoFlZqiVekEiDFzreZxkutvzjCmiKnfJyWHtvBRpjhOLBSjpaKTllLtGqDrRcXPbgcKpRzVysRwZlRdkplzkfBcIbBgkaNuEnnFLJjYGSaVYXzQzNBpakUKH

An issuer needing more information may call the requesting provider directly at: +10814680002