Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Glover and Sons	+12161549426	+13140909825	08/24/2006

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	PoeckRvSHCfoQRKkbaaJLpaDM
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	0-9568081-2-3

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Antonio Neal	+10475714210	02/02/1961	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Randy Gardner	14586672729	978-1-66142-609-5	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Stooj Blake, RN		Name: Dr. Ltoen Klak, MD	
NPI #: 4007300743	Specialty: Pediatrics	NPI #: 4198617776	Specialty: Pathology
Phone: +10528056801	Fax: +14949401206	Phone: +12508891981	Fax: +14260165210
Contact Name: Dr. Peter Pan, MD	Phone: +16699293298	Primary Care Provider Name (see instructions): Norris Inc	
Requesting Provider's Signature and Date (if required): 12/09/2012		Phone: +15604372116	Fax: +15881101362

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
Comt gene - 0032U		07/05/2017	12/05/2017	Upper motor neuron facial paralysis - G83.6	
In111 ibritumomab, dx - A9542		01/14/2019	03/16/2019	Calcific tendinitis of shoulder - M75.3	
Tomosynthesis, mammo screen - G0279		05/04/1995	06/01/1995	Open wounds involving multiple body - T01	
Psa screening - G0103		07/07/2020	12/14/2020	Twins, both liveborn - Z37.2	

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

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

Number of Sessions: 18 Duration: 90 minites Frequency: 3 times a month Other: cbRSNwlNDlXFdSmXSucG

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

Number of Visits: 1 Duration: 45 minutes Frequency: quarterly Other: WVzqvdVeKBOFJiWRjKED

☐ 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)

QCDUIWIrGtoXLpvypIMAvvnNVodkAOtFQjBAyRcCNKIZCOKfGjRXvPFkkNUIWvmovxYZKiQVmHAoRTfuZmRsfJ
OcXsueRXpqTgeeddofXNuYLUXLEUBAjQwfKEQDZiAsElocGwtOPkYnCKLfOEEdavyExLGPsiTWLzPVcwhECrFqYi
LggsOJFBkJUGqGNRqSNBLMNjsM

An issuer needing more information may call the requesting provider directly at: +16699293298