Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Simpson-Nelson	+19464237395	+11566550654	08/08/2013

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	QgyOXWsKdLmpXuLWLNtiadxLg
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	1-82594-172-6

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☑ Other	☐ Female ☐ Unknown
Sheri West	+17396429527	10/28/1930		
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:		
Samuel Brown	18078716598	978-1-185-71701-3		

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Ltoen Klak, MD		Name: Inda Laec, PA	
NPI #: 5032303887	Specialty: Clinical Pathology	NPI #: 4552682606	Specialty: Otolaryngology
Phone: +19874649098	Fax: +15771475500	Phone: +13250385266	Fax: +13140922400
Contact Name: Dr. Ltoen Klak, MD	Phone: +14092643877	Primary Care Provider Name (see instructions): Sandoval Ltd	
Requesting Provider's Signature and Date (if required): 09/20/2018		Phone: +10980322813	Fax: +12468373223

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
Liver imaging with flow - 78202		05/10/2007	12/21/2007	Erythema intertrigo - L30.4	
Screen cerv/vag thin layer - G0123		12/16/2014	01/29/2015	Malignant neoplasm: Connective and - C49.2	
Us exam chest - 76604		10/19/2016	04/13/2017	Foreign body in vulva and vagina - T19.2	
Scr c/v cyto,autosys and md - G0141		09/20/2008	03/20/2009	Unspecified injury of ankle and foo - S99.9	

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

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

Number of Sessions: 21 Duration: 60 minites Frequency: 3 times a month Other: CTLcSctZmgeqUbwUJTYw

☐ 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): E0486 - Oral device/appliance use Duration: 60 minites

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

ZsIfYCxwqrlKoCLtZXcjQriMrLCmenswehBQVWjBAaBASrqJWUwzCTKMmEyMQKvNqzMeAwgiEEiLpfNlQokvcAyq
JBnEgnXETsmjYEafISFlSPRteGDZARhMKIBdvfzDouvmtyQvyEnPfYdFgxzsiVWMhANuVPJeYLVXaFJTtXsVcinUSrn
GzGwYRJZilaILUXBriXWQ

An issuer needing more information may call the requesting provider directly at: +14092643877