Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Herrera-Marshall	+13843243598	+19202794281	10/07/1997

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	fxtpgXJaCvrzaGGXnIKsuJpHD	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	1-59308-739-X	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
James Mendoza	+11532293002	06/30/1964	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Henry Levine	33602956587	978-1-380-36072-4	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Stooj Blake, RN		Name: Dr. Amy Shaw, MD	
NPI #: 1870860371	Specialty: Plastic Surgery	NPI #: 7336159250	Specialty: Preventive Med.
Phone: +11142832914	Fax: +15686856139	Phone: +15284220185	Fax: +12860835109
Contact Name: Dr. Ltoen Klak, MD	Phone: +10578787517	Primary Care Provider Name (see instructions): Rivera, Stewart and Mills	
Requesting Provider's Signature and Date (if required): 04/10/2010		Phone: +13422382979	Fax: +17383987635

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
Lower extremity study - 93926		10/28/2019	06/18/2020	Torticollis - M43.6	
Rp loclzj tum spect w/ct 2 - 78832		07/10/1999	05/22/2000	Other complications following infus - T80.8	
Lung ventilation imaging - 78579		07/12/2009	12/28/2009	Other sexually transmitted chlamydi - A56	
X-ray exam of femur 1 - 73551		01/14/2015	04/13/2015	Polyglandular hyperfunction - E31.1	

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

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

Number of Sessions: 9 Duration: 60 minites Frequency: 2 times a month Other: oSIhXMRkFQUCfGtXqCZM

☐ 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)

QvJKASBHEfIYPrrhTYzpxNvaFPSUByokPpKnQWhObylRPNkipYPkjCFgdBNoYiTUkZWgAvKnRMCHlsgjNPOuMKa
ODNvDzfxCUGAWaTgPkijbwIvSAYtlWbjHiWuWoRCMIZXZvuBUUgETvJSoxiXqUKprldZZvWkWqMUtHDzKmeguiu
NEgMpMAUkUcghQJXsNqWfdpMkr

An issuer needing more information may call the requesting provider directly at: +10578787517