Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Mora, Smith and Lopez	+13362792581	+10177469492	01/01/1995

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	vezSDRlUBHTSeEwFbKAnKPEtC	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-573-17858-5	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other	☑ Female ☐ Unknown
Mrs. Jessica Leblanc	+15355279996	02/17/1993		

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Holly Cox	98937555155	978-1-5159-9934-8

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Peter Pan, MD		Name: Inda Laec, PA	
NPI #: 1416028280	Specialty: Diagnostic Radiology	NPI #: 8920668687	Specialty: General Surgery
Phone: +15518684294	Fax: +15712188826	Phone: +13774666924	Fax: +17772568909
Contact Name: Dr. Ltoen Klak, MD	Phone: +16591543822	Primary Care Provider Name (see instructions): Summers-Walters	
Requesting Provider's Signature and Date (if required): 12/10/2012		Phone: +19675031923	Fax: +16883968681

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
Penile vascular study - 93980		06/30/1993	01/04/1994	Sequelae of inflammatory diseases o -	G09
Cath place cardio brachytx - 92974		08/21/2022	09/27/2022	Injury of colon -	S36.5
Assistive technology assess - 97755		07/08/2013	03/31/2014	Kienböck disease of adults -	M93.1
Use of speech device service - 92609		12/09/1998	06/12/1999	Abnormal haematological finding on -	O28.0

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

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

Number of Sessions: 7 Duration: 120 minites Frequency: daily Other: zcslYjBkpmcdZjkRTyuo

☐ 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): E1399 - Durable medical equipment Duration: 150 minites

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

AFHWrgWPrWCqcFZMSSooarQHtJfkNMrwOAQyMDpGZjamrzMbqllJeBUASaHuvZnvKOMurXuenOMLtwiBssNlrWf
GhlRbEsOGoEYSojmhdPELdqmWidLHrCUHuDhReVZyprjmsvKKbsQYuUjiowqPiHnUBQtsVCgjlWgcGXyZQZRFeM
UCnIuvQaJmkgtjzwTmwMChZZuz

An issuer needing more information may call the requesting provider directly at: +16591543822