Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Doyle LLC	+14697750016	+11257777611	01/25/2020

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	NzaNjPBSgXsjGoXQgTNyNohLT	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-549-25618-0	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Gary Shepard	+19275364966	10/10/1987	
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	
Caitlin Chandler	81127453722	978-1-369-57517-0	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Inda Laec, PA		Name: Stooj Blake, RN	
NPI #: 7941913587	Specialty: OBGYN	NPI #: 5018639104	Specialty: Urology
Phone: +14137868970	Fax: +16639834217	Phone: +12872178884	Fax: +11143159705
Contact Name: Dr. Amy Shaw, MD	Phone: +11908691350	Primary Care Provider Name (see instructions): Spencer, Haynes and Perez	
Requesting Provider's Signature and Date (if required): 10/19/2022		Phone: +17970160578	Fax: +15671846450

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
Radiation treatment aid(s) - 77333		01/08/1997	03/03/1997	Toxic effect: 2-Propanol - T51.2	
Cardiac mri seg dys strain - C9762		10/02/1998	06/13/1999	Other disorders of muscle tone of n - P94.8	
Radiation treatment delivery - G6012		10/08/2002	05/04/2003	Congenital malformation of breast, - Q83.9	
Mr angio upr extr w/o&w/dye - 73225		03/05/2002	05/30/2002	Dysthyroid exophthalmos - H06.2	

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

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

Number of Sessions: 25 Duration: 60 minites Frequency: 3 times a month Other: DjvLayaXtmzgvTQECbud

☐ 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)

FkatyGTdLXXkqcbBiDtURgYwKDUJMWUWoDaTPcLAIqdtMTLrFLsvPJWeBktPoZfdJyedlDlxddmHYZSxangNVkXM
PnmZtZpxDfOluJEazQqvHGKmaRZVccdQGPvzhvhlcaCuAiDTSmmdRoqbDkYAlGmoXelhFzKCdAWrHgoZUawPitjzZc
JoDhDfVsoudlKGvjHFMdNy

An issuer needing more information may call the requesting provider directly at: +11908691350