Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Daniel LLC	+12733232887	+11441769517	04/11/2000

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent		Clinical Reason for Urgency:	mptXHPMmoCmaAkvNkZYNlvgYA
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment		Prev. Auth. #:	0-00-698770-2

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☑ Female ☐ Other ☐ Unknown
Jared Manning	+16461613889	10/25/1978	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Joseph Smith	97391612077	978-0-561-59164-3	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Stooj Blake, RN		Name: Bob Faylor, PA	
NPI #: 1651283579	Specialty: Nuclear Medicine	NPI #: 5644441057	Specialty: Immunology
Phone: +17934512474	Fax: +15579665698	Phone: +15529742699	Fax: +15562853754
Contact Name: Dr. Amy Shaw, MD	Phone: +19835771087	Primary Care Provider Name (see instructions): Navarro PLC	
Requesting Provider's Signature and Date (if required): 07/14/2006		Phone: +14085958405	Fax: +19598058833

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
Covid-19 lab test non-cdc - U0002		09/28/1997	05/31/1998	Arthritis in mycoses - M01.6	
Tomosynthesis, mammo screen - G0279		10/22/2016	10/11/2017	Chronic tonsillitis - J35.0	
Onc clrct ca img alys w/ai - 0261U		10/20/2015	06/30/2016	Blood alcohol level of less than 20 - Y90.0	
Extracranial study - 93880		01/23/2014	11/04/2014	Injury of pancreas - S36.2	

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

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

Number of Sessions: 7 Duration: 60 minites Frequency: daily Other: VPlbxfHbjtnBoVbeVief

☐ 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)

ifucCZVbpanmkzwHImRiznpICJCBTXCbImawJbAbetzlpExrTbqIoqTXIXfmhqiHhSDAeqSzGGObtaqrdbbpMwXscfnIpfd pqcmFchEHclrgopVFuaKZwjrRwIDvaiXCUIAcNHmqlrWITxzcFWdduIXnHiaKDsbhAkIzQCmvasgQJpMFPrXoObIAOs UNtgEYjPHGlNSw

An issuer needing more information may call the requesting provider directly at: +19835771087