Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Davis and Sons	+11016331339	+16581845817	11/14/2007

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	gBDfAPbQEIFTIiZCdUpavSHlX	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	1-240-91621-3	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☑ Unknown
Dr. Brian Mercer	+18340528681	10/13/1966	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Robert Frye	50455464101	978-0-277-95477-0	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Stooj Blake, RN		Name: Stooj Blake, RN	
NPI #: 4046570861	Specialty: Diagnostic Radiology	NPI #: 95341465	Specialty: Diagnostic Radiology
Phone: +11518676160	Fax: +15961157292	Phone: +13849755158	Fax: +17133886489
Contact Name: Dr. Ltoen Klak, MD	Phone: +12214729596	Primary Care Provider Name (see instructions): Montgomery-Rivera	
Requesting Provider's Signature and Date (if required): 10/21/1998		Phone: +16615215030	Fax: +16404644789

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
Lung ventilation imaging - 78579		10/21/2001	11/11/2001	Meckel diverticulum - Q43.0	
IIV4 vacc splt 0.5 ml im - 90688		10/02/2009	10/29/2009	Infection and inflammatory reaction - T85.7	
Sbrt delivery - 77373		03/22/2018	03/14/2019	Foreign body in mouth - T18.0	
Fluzone vacc, 3 yrs & >, im - Q2038		08/17/2006	03/27/2007	Viral hepatitis - B15-B19	

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

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

Number of Sessions: 12 Duration: 150 minites Frequency: quarterly Other: uKrpuMUWVncIWSQTGbVT

☑ Home Health (MD Signed Order Attached? ☐ Yes ☑ No) (Nursing Assessment Attached? ☐ Yes ☑ No)

Number of Visits: 7 Duration: 45 minutes Frequency: quarterly Other: VxILjeJvWudZXKtfMPXf

☑ DME (MD Signed Order Attached? ☐ Yes ☑ No) (Medicaid Only: Title 19 Certification Attached? ☑ Yes ☐ No)

Equipment/Supplies (include any HCPCS Codes): E0791 - Parenteral infusion pump, Duration: 45 minutes

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

tWksvziKAiucCDTLAWSzRjKIFYaOAnlGIqRtVjQRfCizDsYAJwBqjcznekXDhAwMtEhHqOLRzGPcDwQOtDTJadpajW
RvdqKGgcBOrfepbUKkZeebvShGAkzxEsbNPxXbBGmoNRBipMhvcIMmqXZltfntZXoTsPlHHTCTuMqJEpVXJHNIykq
QeQwPCPAWhxUymjnIUCoX

An issuer needing more information may call the requesting provider directly at: +12214729596