Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Hansen-Jones	+18976485523	+14251084095	09/22/2017

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	SuSNRhckUwhWcKLYhWlTNUarg
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	1-910519-78-2

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other	☑ Female ☐ Unknown
Rebecca Green	+18402835053	12/22/1990		

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Mark Tanner	44613451908	978-0-688-19670-7

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Peter Pan, MD		Name: Calk Banks, NP	
NPI #: 254246655	Specialty: Internal Medicine	NPI #: 2190623333	Specialty: Preventive Med.
Phone: +12226353207	Fax: +10808353891	Phone: +18225365431	Fax: +16505952032
Contact Name: Stooj Blake, RN	Phone: +14148202118	Primary Care Provider Name (see instructions): Bradley Inc	
Requesting Provider's Signature and Date (if required): 10/09/2005		Phone: +18547355152	Fax: +12420277904

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
Us exam spinal canal - 76800		05/16/2003	08/11/2003	Appetite depressants [anorectics] - Y57.0	
Breast tomosynthesis bi - 77062		01/30/1995	02/01/1995	Congenital malformations of adrenal - Q89.1	
Lung ventilation imaging - 78579		06/24/1996	05/16/1997	Mixed lesions of pinta - A67.3	
X-ray exam of tailbone - 72220		01/29/2015	03/20/2015	Person injured while boarding or al - V97.1	

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

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

Number of Sessions: 8 Duration: 60 minites Frequency: bimonthly Other: akzvEKhMoCCdBrduwhtp

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

Number of Visits: 9 Duration: 45 minutes Frequency: 3 times a mo Other: qVpECmyyOIwBTfiArBKG

☐ 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)

iiXikLJodJXIFOPgaQaLbHmqDcQcoALSOxJqvRzbMjSCRDAwcGUFkknOkbxPiTYzXLnLiUwvAsxmdzQLoEJeDRjRjit
tCpFrgDBWudTjraEjkrZMzlYVdFUOfjTDdpkfSfbzFwNQtYuhHizBMAUIitQgqMhhmRRJbpnVFPbBBxtUoxJqQcvoAID
xUkgawatIlSWeZOTI

An issuer needing more information may call the requesting provider directly at: +14148202118