Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Mccormick Inc	+19456918240	+11431952908	05/30/2018

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	ANInbyXoavyTkUnrWHFMgleYA	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	1-198-06784-5	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☑ Female ☐ Other ☐ Unknown
Jesse Thomas	+15550638540	12/11/2009	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Christopher Scott	34717950132	978-0-346-09341-6	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Calk Banks, NP		Name: Dr. Peter Pan, MD	
NPI #: 2342631313	Specialty: Plastic Surgery	NPI #: 4781560848	Specialty: Ophthalmology
Phone: +19290129779	Fax: +14294265994	Phone: +14249304266	Fax: +14031776781
Contact Name: Calk Banks, NP	Phone: +10173343677	Primary Care Provider Name (see instructions): Austin-Walker	
Requesting Provider's Signature and Date (if required): 03/28/2009		Phone: +10864349578	Fax: +10004082460

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
Mr elastography - 76391		03/10/1999	01/16/2000	Traumatic amputation of wrist and h - S68	
"Repair of blepharoptosis; frontal - 67901		03/20/1997	07/14/1997	Chronic maxillary sinusitis - J32.0	
Design mlc device for imrt - 77338		09/22/2001	04/23/2002	Laevocardia - Q24.1	
Hematopoietic nuclear tx - 79403		03/17/2016	09/24/2016	Malignant neoplasm of kidney, excep - C64	

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

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

Number of Sessions: 6 Duration: 30 minutes Frequency: monthly Other: FARcMKUQSnvgLQeBeYoG

☐ 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)

JIQWEKRoFqzZGPsfToKzkgJkCUXkDqJfbfolBTvdrkAmClvNaAttcOJYKHbSOlPJCvwZtoIFpWKOWIyczTpphhKbbpE
UdFgOEzaWhOwHRTEdInIkDbjBvsHuheyyizFYSoWwaCCiGzLnXUuinooQfnEBMIcpfZIVEyGwwQTtvlFvNQFIteAkpI
HsYeHLeyerfYzFjobk

An issuer needing more information may call the requesting provider directly at: +10173343677