Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Perry-Martin	+10917579787	+18003587433	02/16/2019

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent		Clinical Reason for Urgency:	UHGWxPVEpJHnCgVGlYCMJMCwC
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment		Prev. Auth. #:	0-381-31834-6

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☑ Female ☐ Other ☐ Unknown
Jordan Lewis	+12672221334	08/30/1979	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Roy Turner	82923906709	978-1-199-20322-9	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Bob Faylor, PA		Name: Bob Faylor, PA	
NPI #: 5387925888	Specialty: Neurology	NPI #: 1285569796	Specialty: Urology
Phone: +12954961306	Fax: +15681284289	Phone: +19736190317	Fax: +18082038256
Contact Name: Dr. Peter Pan, MD	Phone: +14071527714	Primary Care Provider Name (see instructions): Allen, Eaton and Velez	
Requesting Provider's Signature and Date (if required): 03/01/2020		Phone: +19892895310	Fax: +14617463530

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
Ct maxillofacial w/o & w/dye - 70488		05/22/2018	02/08/2019	Inflammatory polyneuropathy - G61	
Screening pap smear by phys - P3001		07/29/2008	10/21/2008	Female chronic pelvic peritonitis - N73.4	
Hiv combination assay - G0475		02/09/2019	03/03/2019	Malignant neoplasms of thyroid and - C73-C75	
Brachytx,non-stranded,I-125 - C2639		12/09/2020	01/14/2021	Secondary and unspecified malignant - C77.1	

☐ 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: 3 times a month Other: xBSGqBpDwCPdOTVHAAhP

☐ 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)

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hTcUpprTxdVNpFTGfOvGJabpQpeMFInGOkheJcyUvDxLJGbdwvQHJAjHNaxYZJwzICUsdvfXDJWmzWhmuoAKqWP
kHKfmCVSXakAXJnwplIrwiVyrqbc

An issuer needing more information may call the requesting provider directly at: +14071527714