Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Fisher, Wood and Smith	+13604525710	+12575908054	09/28/1996

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	yUHJXGTaLRUMbgUZgSgtcwkBC	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	1-67317-234-2	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Lawrence Williams	+17076616066	04/22/1941	
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	
Miss Laura Turner	56816921467	978-0-08-997943-5	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Inda Laec, PA		Name: Dr. Peter Pan, MD	
NPI #: 4090466647	Specialty: Urology	NPI #: 5061758112	Specialty: Psychiatry
Phone: +18667366150	Fax: +17101054227	Phone: +19436978726	Fax: +18924975597
Contact Name: Inda Laec, PA	Phone: +14317896221	Primary Care Provider Name (see instructions): Stephenson Group	
Requesting Provider's Signature and Date (if required): 09/14/2003		Phone: +17811007835	Fax: +10168083192

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
Myocrd img pet 1 std w/ct - 78429		07/28/2003	01/13/2004	Chronic obstructive pulmonary disea -	J44.9
Scr c/v cyto,autosys and md - G0141		09/25/2001	07/27/2002	Special screening examination for n -	Z12.0
Brachytx cesium-131 chloride - C2644		04/13/2013	03/21/2014	Unspecified mental retardation -	F79
CSF shunt evaluation - 78645		11/22/2020	06/17/2021	Other disorders of iris and ciliary -	H22.8

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

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

Number of Sessions: 2 Duration: 120 minites Frequency: biweekly Other: iuCxwQFIrKowgpmHBAnS

☐ 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)

AxjnceTnbsojypJQYUHibhSdKAeGSfVHbkwDoUTBqyqhoIsXPbuzdxIdZutWjLYvycZlrUSHAzCelyGvsHoVyalNhZcIFP
BkVGsWGPDVqrkiVaGtORpjJxVKnAAXxgKFfQDZYynbsZnIFcMwBpmexTddlXsTkcMnaQFmknKgalygdNGryzBtyXz
MfaRhoycWbFhPtqJC

An issuer needing more information may call the requesting provider directly at: +14317896221