Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Walker, Huang and Thompson	+15886711342	+15945206768	06/30/2003

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	hWDZSXTjqqaDmEkuXdWGiKUWx	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	1-159-92382-5	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Ryan Greer	+10408224072	08/19/1963	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Brandy Johnson	39690605054	978-0-425-63667-1	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Inda Laec, PA		Name: Inda Laec, PA	
NPI #: 8281608059	Specialty: Immunology	NPI #: 4102658996	Specialty: Nuclear Medicine
Phone: +13770075114	Fax: +19112637154	Phone: +15583176486	Fax: +19614056884
Contact Name: Bob Faylor, PA	Phone: +19700281468	Primary Care Provider Name (see instructions): Barron-Whitney	
Requesting Provider's Signature and Date (if required): 06/30/2018		Phone: +14467381850	Fax: +18659287079

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
Hepb vaccine 3 dose adult im - 90746		03/28/2017	09/30/2017	Balanced sex/autosomal rearrangemen	- Q95.3
Smn1&smn2 full gene analysis - 0236U		12/16/2014	10/16/2015	Occupant of three-wheeled motor veh	- V37
F18 fdg - A9552		12/21/2018	01/12/2019	Need for immunization against pertu	- Z23.7
Special radiation treatment - 77470		05/12/1998	07/18/1998	Accident to watercraft causing drow	- V90

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

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

Number of Sessions: 24 Duration: 120 minites Frequency: weekly Other: AOHwMUJjWZsldTnAnRgm

☐ 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)

NiILzFFRFgJvcIVjBVARYTncMBalchfHJwBtVNxEClJhqXFkjcEglwZlndfOGHbfBEwoMNWRwTQxOsmujKXZtFJkzh
CiqiRDxOCjnvtwldrkgzKfiKsOHUsyhQIxOEnSakgamwjuebsKKvzRqPNxNAvPfhRVrcRJCclKUJaGjSIluMtUJLYelTSqu
upWmukndiVxJFlp

An issuer needing more information may call the requesting provider directly at: +19700281468