Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Cameron Inc	+18596837322	+13650057560	11/02/2001

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	SuEJfkuFlBclLmTqfQjCyjKog	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-7617-9011-X	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Amy Patel	+19251509455	06/03/1991	
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	
Emily Wright	63307839147	978-0-7427-8503-8	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Bob Faylor, PA		Name: Dr. Peter Pan, MD	
NPI #: 2195378452	Specialty: Pediatrics	NPI #: 5033195001	Specialty: General Surgery
Phone: +18331352361	Fax: +12933444230	Phone: +14742814741	Fax: +15061956397
Contact Name: Dr. Ltoen Klak, MD	Phone: +17176019386	Primary Care Provider Name (see instructions): Jones Inc	
Requesting Provider's Signature and Date (if required): 04/15/2009		Phone: +13876389178	Fax: +12656645169

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
Gated heart multiple - 78473		02/07/1997	08/08/1997	Other diseases of capillaries - I78.8	
Ct angiography head - 70496		11/16/2017	11/08/2018	Congenital heart block - Q24.6	
Ins mark thor for rt perq - 32553		07/30/2012	03/31/2013	Other forms of sporotrichosis - B42.8	
Us exam k transpl w/Doppler - 76776		06/18/2016	01/09/2017	Injury of adductor muscle and tendo - S76.2	

☐ 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: 150 minites Frequency: 2 times a month Other: HAayAqmfVlnMKmUDgJVj

☐ 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): E0486 - Oral device/appliance use Duration: 150 minites

Section VI — Clinical Documentation (See Instructions Page, Section VI)

rydSJzUnLzXCauauTyqXWqKKUpoxSoJBnnrdTxtjhRcHNXxiRkhLJaRGkTvGObNbtWBGltCgpvFFMlvGCKPtJTqYobd
aUThqxykLFIKDAMeEeYGOpxHfdKUZoTTlrVDeaZBbbItsVGRqJKJwfvWqpqZlUfRbYlqEkKnaIjqasXvdmkQBOesdw
uWpIREPiffnluAkkaCs

An issuer needing more information may call the requesting provider directly at: +17176019386