Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Murray Group	+18323259749	+11599573713	05/23/2013

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	JtUIgEhgbmhlzivcsojAziyHc
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	1-71366-522-0

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Dr. Heather Griffin	+17858218934	07/02/1946	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Mary Mcdowell	75381164849	978-1-72908-751-0	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Bob Faylor, PA		Name: Calk Banks, NP	
NPI #: 4208890673	Specialty: Ophthalmology	NPI #: 6586892267	Specialty: Neurology
Phone: +18653927507	Fax: +16149888329	Phone: +17836775277	Fax: +12023592561
Contact Name: Bob Faylor, PA	Phone: +15418864984	Primary Care Provider Name (see instructions): Forbes, Castillo and Wallace	
Requesting Provider's Signature and Date (if required): 02/06/2006		Phone: +16920508373	Fax: +14848326912

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
Trgt gen seq alys pnl 311+ - 0239U		07/26/2018	08/11/2018	Adjustment and management of other - Z45.8	
Tc99m pertechnetate - A9512		11/16/2009	12/29/2009	Occupant of pick-up truck or van in - V53.4	
Aquatic therapy/exercises - 97113		04/26/2008	11/19/2008	Other specified obstructed labour - O66.8	
Elisa hiv-1/hiv-2 screen - G0433		07/01/2010	10/13/2010	Cholera due to Vibrio cholerae 01, - A00.0	

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

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

Number of Sessions: 17 Duration: 90 minites Frequency: yearly Other: mxdFVXniRuBSLEClwcnb

☐ 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)

KnXQZAHlRjXCzDPSmkeNTqvPTbVvhfxtDEgTdzhzHtpSMcAyKPzQWEgqTUMGHRrYbMkuxojfnBCgNWbsRqaKyVmvQWVnPCyLgfguKtewjrfnaqIHmFVjTBBHbztqIrRJTSVkObxwEmUPJSAERGrlvEJRCHuJEZMLTsgaXdQNXqQDrjaxMjECnjMWEwAHCOOZFBSBvbqU

An issuer needing more information may call the requesting provider directly at: +15418864984