Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Fowler, Calhoun and Collins	+11235316212	+10841148784	05/16/2012

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	RJegHnUyUSVicfzZLteMXLVhC	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	1-5032-2504-6	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Billy Washington	+15361383683	06/07/1996	

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Casey Campbell	14256303998	978-1-107-71663-6

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Stooj Blake, RN		Name: Bob Faylor, PA	
NPI #: 228495813	Specialty: Allergy	NPI #: 7106013889	Specialty: Neurology
Phone: +15189181044	Fax: +19492088426	Phone: +14582063780	Fax: +13541337430
Contact Name: Bob Faylor, PA	Phone: +19603453646	Primary Care Provider Name (see instructions): Gibson PLC	
Requesting Provider's Signature and Date (if required): 08/30/1994		Phone: +15979336255	Fax: +14318770011

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
Cypia2 gene - 0031U		06/15/1999	05/25/2000	Other postprocedural respiratory di - J95.8	
RIV3 vaccine no preserv im - 90673		01/18/2022	08/21/2022	Vanadium deficiency - E61.6	
Cine/video x-rays add-on - 76125		12/16/2001	02/09/2002	Haematometra - N85.7	
X-ray xm upr gi trc 1cntrst - 74240		04/05/2011	03/06/2012	Other hyperphenylalaninaemias - E70.1	

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

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

Number of Sessions: 24 Duration: 120 minites Frequency: yearly Other: tosoDEggBnAGgWhFLhqI

☐ 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)

gXabCvsHWjbxydxGyuNbBoNHrsOpxiLdNGyvJqmAeoHVrPxusKXDvVbYnQDetRSfCOIJDfiLJDIWthNSjeOEMrSkFQ
RhhLePumofktkIWIEFHYLBTkCsaNkGfrlCoAViHDbizHXbebwgUddeWZGpYoeUquaguoMlpDRkzhRlVPnyMVlHoQrK
abbGpoCjSEAVmslhMBjb

An issuer needing more information may call the requesting provider directly at: +19603453646