Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Wagner, Jones and Hill	+11119305168	+12376646346	08/16/2009

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	WEJJtyIsTiOLXXXvIyIKHOoZm	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	0-230-99513-6	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
James Collier	+18476414574	09/18/2006	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Stephanie Bond	94025397439	978-1-162-80482-8	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Inda Laec, PA		Name: Dr. Peter Pan, MD	
NPI #: 7656847342	Specialty: Pediatrics	NPI #: 2871489687	Specialty: Otolaryngology
Phone: +18604470586	Fax: +19374257876	Phone: +11626901805	Fax: +17898370652
Contact Name: Dr. Peter Pan, MD	Phone: +12090250163	Primary Care Provider Name (see instructions): Welch Group	
Requesting Provider's Signature and Date (if required): 09/10/1998		Phone: +15092245166	Fax: +15725175860

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
LAIV4 vaccine intranasal - 90672		05/19/2005	03/15/2006	Malignant neoplasm: Lower-outer qua	- C50.5
X-ray exam sacroiliac joints - 72200		06/23/2013	11/30/2013	Other mood [affective] disorders - F38	
Vascular study - 93975		04/17/2015	03/22/2016	Other specified disorders of bone - M89.8	
Rx mntr 14+ drugs & sbsts - 0054U		01/07/1995	11/13/1995	Urinary catheterization - Y84.6	

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

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

Number of Sessions: 15 Duration: 90 minites Frequency: quarterly Other: SDXSblmbbXzHxrLESJlb

☐ 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)

iaJWwWlKxhJSODLXHIcBlQQSLnZRHGvKaDLwgNChvFEVZXVdNogWBQFUIvHFeVzlIwIdBnqKCrQvvhuQyJbjoh
mZNxxAjvzaCFtftnRzOCXWOOXoMEcSWJqHQJJxZsnJrNeMFBeGfeSOVwiKWZbZqceXfKEYGTVIhCGLZGwGflSN
gvYttucoholSqDSevuYNmfezRVAr

An issuer needing more information may call the requesting provider directly at: +12090250163