Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Fuentes, Young and Graves	+16620480903	+17145990997	04/02/2011

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	kuxTAOAOlfYxWuePTfXxxcqCG	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	1-385-36962-0	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Michael Casey	+19322132998	02/09/1937	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Stephen Gilbert	26701781006	978-1-75717-979-9	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Peter Pan, MD		Name: Dr. Ltoen Klak, MD	
NPI #: 229728476	Specialty: Ophthalmology	NPI #: 7690589094	Specialty: Plastic Surgery
Phone: +16022869066	Fax: +16824441966	Phone: +12497342544	Fax: +15968122598
Contact Name: Dr. Ltoen Klak, MD	Phone: +10453325988	Primary Care Provider Name (see instructions): Garcia-Arnold	
Requesting Provider's Signature and Date (if required): 01/01/1994		Phone: +16221989459	Fax: +18842756855

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
Bone marrow imaging body - 78104		03/28/2020	05/03/2020	Examination for normal comparison a - Z00.6	
Set radiation therapy field - 77290		08/10/2021	11/10/2021	HIV disease resulting in candidiasi - B20.4	
Cell enumeration phys interp - 86153		08/03/1994	12/01/1994	Potter syndrome - Q60.6	
Ct angio abd&pelv w/o&w/dye - 74174		11/30/1994	11/01/1995	Other shoulder lesions - M75.8	

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

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

Number of Sessions: 14 Duration: 120 minites Frequency: bimonthly Other: swNNiWeTLRSbHrOeufYo

☐ 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)

DugzrCWQiaxQZJciQLMYwbHmHTkqKsbvDIsTWMvRSuhjbMgAucrrmdfvURuCeDlESdlJOQPkWHCgqOUXwEQBjBtSkQaBIhOllSsMBQxYXOBffhnWBoBYMQPAYiuWHpczpEppcdzccWeDIJahVwdhkWsPZaVVomXSVrSHCtTmbqZfhtvVPBgKmPKsjnttePpcfQYxdBIO

An issuer needing more information may call the requesting provider directly at: +10453325988