# Texas Standard Prior Authorization Request Form for Health Care Services

Clear Form | Print

## Section I — Submission

| Issuer Name: | Phone: | Fax: | Date: |
|---|---|---|---|
| Allen-Sanchez | +17660788771 | +16277602340 | 05/13/2021 |

## Section II — General Information

| | | | |
|---|---|---|---|
| Review Type: ☑ Non-Urgent ☐ Urgent | | Clinical Reason for Urgency: | CNYFzfZGCOBHhruCdKViBAmLu |
| Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment | | Prev. Auth. #: | 1-208-43417-9 |

## Section III — Patient Information

| Name: | Phone: | DOB: | ☐ Male ☐ Other | ☑ Female ☐ Unknown |
|---|---|---|---|---|
| Joshua Jones | +12778519250 | 07/15/1928 | | |

| Subscriber Name (if different): | Member or Medicaid ID #: | Group #: |
|---|---|---|
| Jesse Hernandez MD | 63513372561 | 978-0-940974-79-1 |

## Section IV — Provider Information

| Requesting Provider or Facility | | Service Provider or Facility | |
|---|---|---|---|
| Name: Stooj Blake, RN | | Name: Dr. Ltoen Klak, MD | |
| NPI #: 2005148596 | Specialty: Neurological Surgery | NPI #: 4529581556 | Specialty: Ophthalmology |
| Phone: +19578949491 | Fax: +16201669241 | Phone: +15407418757 | Fax: +11936426431 |
| Contact Name: Stooj Blake, RN | Phone: +11420520990 | Primary Care Provider Name (see instructions): Johnson-Byrd | |
| Requesting Provider's Signature and Date (if required): 10/25/2012 | | Phone: +15023702564 | Fax: +15074704158 |

## 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 |
|---|---|---|---|---|---|
| Hem gen hyprfibrnlysis 8 gen - 0273U | | 05/25/2014 | 08/27/2014 | Conditions involving the integument - | P80-P83 |
| Onc bladder mrna 209 gen alg - 0016M | | 05/01/1995 | 06/10/1995 | Special screening examination for d - | Z13.0 |
| Tc99m fanolesomab - A9566 | | 08/25/1994 | 01/25/1995 | Renal failure - | N17-N19 |
| Brachytx, non-stranded,C-131 - C2643 | | 10/23/2010 | 07/14/2011 | Localized oedema - | R60.0 |

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

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

Number of Sessions: 19 Duration: 150 minites Frequency: bimonthly Other: UqQFPfiFIHTERyjOfgvR

☐ 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)

XliSgmdXLKpxlWmUpFfzbSNbzFhEXJOZIRHztNUIWdMkkaqBRTkinLlgbzhFdRtnMOstuXcgCtWTNHbXLjLBkiXEMhFXblJjAALDVSXLUaGwTXbxDwbeSUzmKjOlBwsTgSqptvFtWffGNJmSqnnkDxdtttfIeEvoIUvKmpyCVrmQiaoPwvWggixFFSpwjLlJxUpCMBSAm

***An issuer needing more information may call the requesting provider directly at:*** +11420520990