Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Johnson Ltd	+11903193543	+14222540713	09/20/2020

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	TbezvbxqqAYHjBftQYWIAYPGq
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	0-00-792770-3

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☑ Unknown
Mr. William Cervantes	+14741072365	09/28/2022	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Thomas Guzman	6698726325	978-1-955668-25-5	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Calk Banks, NP		Name: Inda Laec, PA	
NPI #: 9082861563	Specialty: Orthopedic Surgery	NPI #: 4625347239	Specialty: Internal Medicine
Phone: +11030329311	Fax: +14902883154	Phone: +16338451525	Fax: +12842777365
Contact Name: Dr. Peter Pan, MD	Phone: +18679762981	Primary Care Provider Name (see instructions): Brown, Jones and Sandoval	
Requesting Provider's Signature and Date (if required): 06/01/2018		Phone: +14574507199	Fax: +15965673556

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
Fluvirin vacc, 3 yrs & >, im - Q2037		09/02/2010	08/18/2011	Occupant of three-wheeled motor veh - V30.0	
Pt eval mod complex 30 min - 97162		05/14/1997	01/30/1998	Other chronic haematogenous osteomy - M86.5	
Ct breast w/3d bi c+ - 0637T		04/21/1998	04/28/1998	Other congenital ichthyosis - Q80.8	
Neuro csf prion prtn qual - 0035U		04/19/2009	05/18/2009	Diseases of liver - K70-K77	

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

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

Number of Sessions: 9 Duration: 150 minites Frequency: 3 times a week Other: KnEhyAXBiMDessEBQNvV

☑ Home Health (MD Signed Order Attached? ☑ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☑ No)

Number of Visits: 11 Duration: 120 minites Frequency: daily Other: ChDdioljuGgacIGUqLQf

☐ 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)

NVcHwxvoiXbbfBjXHseHLmXwRqfAJPNSVeAcAApQHNcgPQpAAUZtOehVEsgxHhjrkmJjFWoHlZTtunuDqyswRsrAr
UrSkEdLZvApPNQEmLmMivNxktChuHDvQczxvopWAJirazoXlJxElRkxPkgitZSXOSvLEbJGWFnUcpTowYPkmPCRM
ENomWvivQyILWBgpfrPQxTO

An issuer needing more information may call the requesting provider directly at: +18679762981