

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Clear Form Print

Issuer Name: Landry Group	Phone: +17186084724	Fax: +17818996070	Date: 07/26/2009
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SECTION II — GENERAL INFORMATION

Review Type: <input checked="" type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency: uaguwSLkIQJPVHIXmAlsMaadj
Request Type: <input checked="" type="checkbox"/> Initial Request <input type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #: 1-4317-9587-9

SECTION III — PATIENT INFORMATION

Name: Jeffrey Collins	Phone: +11900485140	DOB: 06/20/1924	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Subscriber Name (if different): Charles Johnson	Member or Medicaid ID #: 54201882124	Group #: 978-1-135-33273-0	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name: Calk Banks, NP		Name: Dr. Amy Shaw, MD	
NPI #: 2446809043	Specialty: Neurology	NPI #: 7720760385	Specialty: Allergy
Phone: +10122494084	Fax: +19897645154	Phone: +15195175806	Fax: +11637871188
Contact Name: Bob Faylor, PA	Phone: +16221236194	Primary Care Provider Name (see instructions): Walker PLC	
Requesting Provider's Signature and Date (if required): 07/15/2009		Phone: +13636306850	Fax: +11554794899

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
Cad cxr remote - 0175T		07/25/2005	08/15/2005	Infections of the genital tract in - O23.5	
X-ray exam neck spine 3/					
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Provider Office <input type="checkbox"/> Observation <input type="checkbox"/> Home <input type="checkbox"/> Day Surgery <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Mental Health/Substance Abuse					
Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____					
<input type="checkbox"/> Home Health (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Nursing Assessment Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No)					
Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____					
<input type="checkbox"/> DME (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Medicaid Only: Title 19 Certification Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No)					
Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____					

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

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