Texas Standard Prior Authorization Request Form for Health Care Services

Clear Form | Print

Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Barton, Gay and Berry	+10225349488	+18918478069	01/09/1996

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	eVytQrCYRcTSkoeDhPLcpkHVb	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	1-82399-097-5	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Breanna Mitchell	+19129198375	04/05/2016	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Michelle Evans	50565784691	978-0-629-15900-6	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Bob Faylor, PA		Name: Calk Banks, NP	
NPI #: 9813325182	Specialty: Pathology	NPI #: 5900081366	Specialty: Anesthesiology
Phone: +19150376430	Fax: +10864453013	Phone: +12631706161	Fax: +15446695210
Contact Name: Calk Banks, NP	Phone: +12479115883	Primary Care Provider Name (see instructions): Smith, Branch and Freeman	
Requesting Provider's Signature and Date (if required): 09/27/1997		Phone: +14558088613	Fax: +18187958881

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
Ct breast w/3d bi c+ - 0637T		07/31/2010	08/16/2010	Median rhomboid glossitis - K14.2	
HIV combination assay - G0475		11/22/1998	06/22/1999	Renal tubulo-interstitial disorders - N16.3	
X-ray exam of femur 2/> - 73552		12/14/2010	10/25/2011	Other recurrent mood [affective] di - F38.1	
Qnhp ol dig assmt&mgmt 21+ - 98972		12/19/1992	07/26/1993	Other neonatal aspiration syndromes - P24.8	

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

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

Number of Sessions: 7 Duration: 60 minites Frequency: biweekly Other: LCxAOeGmkwBiCmtfFbGb

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

Number of Visits: 13 Duration: 150 minites Frequency: bimonthly Other: bHeDDmavjqMOghUlOBxk

☐ 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)

MRRrSfAMyOVCLTaOKZCwqtoHRLZHWcRntshweDoQtOkyZdhwcbHGqHuwjcScksHLbkuOaEShtrvfnRjgBkDaMBD
BcJYRLzsTjIWUSeMknSUMcDuPKOfIKsEByTBxLVHjHLkYnbDaqPcvpISdquJiYYsVJbvDpGZkkcKKfMBNDZtnvNU
BUEucbsMTFjrrfmBKwGcTKcFj

An issuer needing more information may call the requesting provider directly at: +12479115883