Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Glenn, Robinson and Lowe	+14729725845	+12870676859	02/10/1995

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	UYDTLPeRYoBiNsuxsMNRnMfMK
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	0-637-21901-5

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Julie Coleman	+10060954548	03/23/2021	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Heather Wells	72812801312	978-1-56275-646-8	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Bob Faylor, PA		Name: Bob Faylor, PA	
NPI #: 6592378264	Specialty: Family Medicine	NPI #: 9569196569	Specialty: Urology
Phone: +14236644283	Fax: +13770441993	Phone: +10355050734	Fax: +13567129144
Contact Name: Calk Banks, NP	Phone: +14958338454	Primary Care Provider Name (see instructions): Gates Group	
Requesting Provider's Signature and Date (if required): 09/04/2011		Phone: +11155279068	Fax: +12519956782

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
Red cell mass multiple - 78121		01/24/2016	05/28/2016	Fetus and newborn affected by mater -	P01.6
Onc prst8 ca mrna 12 gen alg - 0011M		06/10/2010	01/18/2011	Crushing injury of other parts of f -	S57.8
Bone imaging limited area - 78300		10/15/1993	03/01/1994	Urethritis and urethral syndrome -	N34
Electromagntic tx for ulcers - G0329		05/22/2020	07/23/2020	Lumbar spina bifida with hydrocepha -	Q05.2

☐ 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: 30 minutes Frequency: 3 times a month Other: LPpMeXJDcpkFGtatMzhG

☐ 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)

HMBdAklGIIJDAEIQCmKwdfMaubavhlmPkLLRHuyHclNMVzaCybJsOieRvpwTYBsbJVVAKeZVDoHGIqKNJkbujpD
BesPVxAKwiFwJGozfkFOzLwMJyOGirMZSzMjYeXzmqxdQJPPPgwDyVALsxkkepEaZUFwZdKAOJLrAskMntzlwFfRh
cmxzywHWrzhSHYucPlkklRtD

An issuer needing more information may call the requesting provider directly at: +14958338454