Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Kerr PLC	+17669152162	+16378159779	07/23/2016

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	nneNFRoOhYuqUdDsbFWlMectO	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	0-339-99802-4	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other	☑ Female ☐ Unknown
Stacy Thompson	+18510856764	09/13/1960		
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:		
Terry Murray	46960853800	978-1-60294-003-1		

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Peter Pan, MD		Name: Dr. Peter Pan, MD	
NPI #: 9637289182	Specialty: Urology	NPI #: 1604667912	Specialty: Emergency Medicine
Phone: +13091725510	Fax: +12123565055	Phone: +10533484366	Fax: +13189001433
Contact Name: Dr. Amy Shaw, MD	Phone: +16535353084	Primary Care Provider Name (see instructions): Yu, Farley and Adams	
Requesting Provider's Signature and Date (if required): 10/03/2004		Phone: +19348470217	Fax: +18974849717

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 neck spine w/dye - 72126		01/20/2011	01/01/2012	Epicranial subaponeurotic haemorrha - P12.2	
X-ray exam of thoracic spine - 72074		10/28/1998	03/24/1999	Sequelae of other specified injurie - T90.8	
Us exam abdo back wall lim - 76775		02/18/2022	06/08/2022	Shoulder lesions - M75	
X-ray xm colon 2cntrst std - 74280		05/22/2007	10/28/2007	Convalescence following surgery - Z54.0	

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

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

Number of Sessions: 14 Duration: 90 minites Frequency: monthly Other: GecyiLBGoGvToUROJEri

☐ 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): E0730 - Transcutaneous electrical Duration: 90 minites

Section VI — Clinical Documentation (See Instructions Page, Section VI)

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HruSPlysHuXzSvVOUuhfFaWWijZpGcXNyZOHcZMaBazuRvZuaLsDTqdcHhTpRWpkCcbDRONKBtnoRlosyebTaopkL
uKPbQVALEUUVYItcIGzwt

An issuer needing more information may call the requesting provider directly at: +16535353084