Texas Standard Prior Authorization Request Form for Health Care Services

Clear Form | Print

Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Crawford, Baldwin and Carter	+11211391869	+12730791074	03/25/2002

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	OZSWiFuQiKvXDgtmWGwkpFEgT	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	1-68114-859-5	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☑ Unknown
Matthew Gomez	+14547240335	07/17/2002	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Ronald Phillips	1166673449	978-0-641-26881-6	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Bob Faylor, PA		Name: Calk Banks, NP	
NPI #: 1103875091	Specialty: Physical Medicine	NPI #: 3925184577	Specialty: Emergency Medicine
Phone: +18572888817	Fax: +19675143697	Phone: +16544554894	Fax: +16123022705
Contact Name: Inda Laec, PA	Phone: +18032781506	Primary Care Provider Name (see instructions): Long-Peterson	
Requesting Provider's Signature and Date (if required): 02/26/2018		Phone: +14481641080	Fax: +15790902168

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
Nfct ds 22 trgt sars-cov-2 - 0202U		12/04/2002	02/14/2003	Poisoning: Ganglionic blocking drug -	T44.2
Laryngeal function studies - 92520		04/11/2011	09/17/2011	Other histiocytosis syndromes -	D76.3
Pls echo us b1 dns meas tib - 0508T		03/27/2006	12/27/2006	Overdose of radiation given during -	Y63.2
X-ray exam of leg infant - 73592		01/12/2004	03/19/2004	Intracranial hypotension following -	G97.2

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

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

Number of Sessions: 21 Duration: 150 minites Frequency: yearly Other: GttZPSAsYYZEcMnfpxrr

☐ 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): E1390 - Oxygen concentrator Duration: 45 minutes

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

JYYMiGYkxfqbHpNMzUfxdDysjUnTqKcblFiGLsbWGicRxOoTqGGrguMbgMlJjSiDFwzneKvzcSzoBPkWIBGqULDQS
PEKaFBMZgMyhqrRexSaPLnwKgGMSKrVWBPavWVoiehLrjlSNglbpznYJRlehqCbOaEjHiilqCkAeJqEpBBImtxdHQR
mQlMUIbXsrOAwOkYYdeei

An issuer needing more information may call the requesting provider directly at: +18032781506