Texas Standard Prior Authorization Request Form for Health Care Services

Clear Form | Print

Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Lewis-Nguyen	+19775254110	+11123882285	06/07/2017

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	ejxzhOuXCzJpajJSJrVjgEnGR	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	1-369-09996-7	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Bridget Miller	+19551166144	10/23/1984	
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	
Katrina Dominguez	60956466555	978-1-74516-827-9	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Ltoen Klak, MD		Name: Inda Laec, PA	
NPI #: 2517932737	Specialty: Anesthesiology	NPI #: 3863823350	Specialty: Neurological Surgery
Phone: +11227141945	Fax: +14801745962	Phone: +10672096568	Fax: +12441600016
Contact Name: Inda Laec, PA	Phone: +15590875408	Primary Care Provider Name (see instructions): Griffin, Fields and Warren	
Requesting Provider's Signature and Date (if required): 06/08/2015		Phone: +13912124526	Fax: +13415475319

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		07/30/2021	01/01/2022	Contusion of thorax - S20.2	
Vol reduction of blood/prod - 86960		08/13/2002	12/20/2002	Benign lipomatous neoplasm of skin - D17.2	
Radiation treatment delivery - G6009		02/11/2016	10/10/2016	Other histiocytosis syndromes - D76.3	
Use 1st target lesion - 76982		08/05/1997	09/07/1997	Other pulmonary valve disorders - I37.8	

☐ 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: 30 minutes Frequency: yearly Other: VZTibyGCfmEGYVRRkLaS

☐ 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)

xnHEhAtmFWDJGvibpkAgCyxenHMKoOgFXFJMlbxpOPEZRPurxsngRyMDtQgsMasSaWDamXeswcaofEeAgfQacrER
qjgATmhxrnbxxwAuLqkBqyWGALFAOkTvqmsbwQdzNjSFxKwpxzaxqNxMavILTuyqiAYbhgWrqnWkoZRpUuzcjLsuqp
pVQrdyAWMbqMhFUnJHznqh

An issuer needing more information may call the requesting provider directly at: +15590875408