Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Lopez-Terry	+15754669010	+19099426876	11/03/2020

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	OCPwcgfANfNryKxiLHfUyJosV
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment		Prev. Auth. #:	1-75033-407-0

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Jason Rios	+13829312957	07/09/1954	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Tracy Jenkins	36551276398	978-0-651-90027-0	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Stooj Blake, RN		Name: Dr. Peter Pan, MD	
NPI #: 6017773405	Specialty: Orthopedic Surgery	NPI #: 6870746210	Specialty: Internal Medicine
Phone: +17790827188	Fax: +13020987505	Phone: +12786869081	Fax: +11268418418
Contact Name: Inda Laec, PA	Phone: +12519128322	Primary Care Provider Name (see instructions): Gonzales-Murphy	
Requesting Provider's Signature and Date (if required): 10/04/2020		Phone: +16943059822	Fax: +13818834803

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
X-ray exam of ankle - 73610		10/03/2004	03/18/2005	Hypostatic pneumonia, unspecified - J18.2	
Glucose test [only when billed with - 82950		07/30/2007	07/31/2007	Other mononeuropathies of lower lim - G57.8	
IIV no prsv increased ag im - 90662		05/09/2010	08/04/2010	Inguinal hernia - K40	
X-ray exam of pelvis - 72190		06/05/1999	03/03/2000	Other birth injuries - P15	

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

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

Number of Sessions: 17 Duration: 150 minites Frequency: biweekly Other: sULVhWNNAIfMkBwDGAJU

☐ 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)

pogeuafuAaAOdbBJkLgyCqJvsWNIkKtPUgLBGlgdPiRGiKEaHcakSpdKIdRhHgsJGVZSzxllKEWdeqkvtuVwVQOaUIRJ
mgVsAQNYveWobeFYSGxVDcfgktUrzQWTYSaQspRCtUuIqWYnRUczOqBSgnRYoWFmoDdomMUGjSnumEuthTfqQ
SUSOrFWURUBWTBeziwVhaXW

An issuer needing more information may call the requesting provider directly at: +12519128322