Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Morgan, Williams and Wilson	+11487094991	+15670377759	09/13/2012

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	CEaYPNyqTzmJGLloSkAZSGFtz	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-19-830539-7	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Sandra Serrano	+16089957454	09/02/1951	

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Amber Boyd	75448560292	978-0-02-177333-6

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Amy Shaw, MD		Name: Dr. Peter Pan, MD	
NPI #: 8244805081	Specialty: Medical Genetics	NPI #: 3798110540	Specialty: Physical Medicine
Phone: +12388875529	Fax: +15580209913	Phone: +10850563520	Fax: +18077295063
Contact Name: Inda Laec, PA	Phone: +16892144126	Primary Care Provider Name (see instructions): Sweeney, Kennedy and Sharp	
Requesting Provider's Signature and Date (if required): 06/26/2009		Phone: +13964028828	Fax: +13471047644

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
Tc99m exametazime - A9521		08/08/2001	09/29/2001	Other congenital deformities of hip - Q65.8	
Cstb full gene analysis - 0232U		04/02/2011	12/11/2011	Crushing injury of larynx and trach - S17.0	
SRS spinal lesion addl - 63621		03/18/2003	06/12/2003	Malignant neoplasm: Female genital - C57.9	
Place breast cath for rad - 19297		05/11/1997	10/18/1997	Otitis media in other diseases clas - H67.8	

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

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

Number of Sessions: 24 Duration: 150 minites Frequency: daily Other: GaRKYiDeAFouFMvdoPti

☐ 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)

MQeZOEGfoZkyqXORWrfaQbXlGLeCAiLCfMeXuqxtrTlrHZIqcSqPoCRtkKfJIJFRqmyzdkIVwjtIWzPBiqtPUWAzmxfnbakrrFZmlGgvnJREmlaiJubbXFfcQjrNrtarKqGuHxXQUrrhJTejjeDVnZKKZtonHMezWninMEVVlGJXFuBbaaUCrybziOYdwNIvitPyqfFl

An issuer needing more information may call the requesting provider directly at: +16892144126