Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Harris Ltd	+17070951291	+19408614100	07/11/2020

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	mbTdLNicngmWcyHUmfyTHInmn
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	0-299-32750-7

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
David Olsen	+11958759617	01/11/1963	
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	
David Wong	58374807992	978-0-240-70160-8	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Amy Shaw, MD		Name: Dr. Peter Pan, MD	
NPI #: 4028558643	Specialty: Otolaryngology	NPI #: 3873345405	Specialty: Allergy
Phone: +16672103415	Fax: +16212062079	Phone: +19957910951	Fax: +10058841192
Contact Name: Bob Faylor, PA	Phone: +10277056335	Primary Care Provider Name (see instructions): Harrison-Lucas	
Requesting Provider's Signature and Date (if required): 05/10/2010		Phone: +13262933124	Fax: +13753869238

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
Mr angio pelvis w/o & w/dye - 72198		07/07/2021	12/02/2021	Sarcoma of dendritic cells (accesso - C96.4	
Rp loclzj tum spect 2 areas - 78831		09/17/2005	03/19/2006	Other postprocedural musculoskeleta - M96.8	
Tpmt nudt15 genes - 0034U		12/09/1999	12/13/1999	Rash and other nonspecific skin eru - R21	
X-ray exam of elbow - 73080		09/01/1997	12/01/1997	Disorders of skin appendages - L60-L75	

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

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

Number of Sessions: 15 Duration: 150 minites Frequency: 2 times a week Other: WrLgWkxVvwpIfeSKuryz

☐ 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: 150 minites

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

cFTMwrCYGGzCQafhrhgpXoQrqrkWHtkvlLbNGVYCnpibGuXZedGceZfKZuffZSNvYdtHImfjOGjMlEqVuMCAFSKfk
gwDJKHupMQTyYuGMlljPxtHtuSwxmjXYgaQGwEIWBjRfEVCOLoWObQwRviRETtufEjiSwjyuIciUKScwXyotbrkjoiy
OLxbiXKeBdCQnwSiayYY

An issuer needing more information may call the requesting provider directly at: +10277056335