Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Sanders PLC	+14939344646	+19435902157	06/22/2011

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	dJIcPNfJOsWcAeXpHlLZhlMZK	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	1-79096-712-0	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Jason Huffman	+11770258385	04/15/1940	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Heather Pollard	90396170484	978-0-8173-6469-4	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Stooj Blake, RN		Name: Dr. Amy Shaw, MD	
NPI #: 9432831781	Specialty: Medical Genetics	NPI #: 9759061689	Specialty: Nuclear Medicine
Phone: +17062559256	Fax: +14863139059	Phone: +14077384622	Fax: +12342820383
Contact Name: Stooj Blake, RN	Phone: +17412955711	Primary Care Provider Name (see instructions): Bartlett, Rivera and Miles	
Requesting Provider's Signature and Date (if required): 08/27/2006		Phone: +14418147527	Fax: +13950507739

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
Mri breast c-+ w/cad bi - 77049		06/23/1994	11/01/1994	Vascular myelopathies - G95.1	
Red cell survival study - 78130		02/01/2009	06/25/2009	Essential tremor - G25.0	
Radiation treatment delivery - G6003		03/19/1998	04/24/1998	Alveolar and parietoalveolar condit - J84.0	
Red cell sequestration - 78140		09/29/2022	05/03/2023	Carcinoma in situ: Skin of scalp an - D04.4	

☐ 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: 45 minutes Frequency: 2 times a week Other: lkvBRdUostAGmZOzqZdt

☑ Home Health (MD Signed Order Attached? ☑ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☑ No)

Number of Visits: 8 Duration: 60 minites Frequency: 2 times a month Other: BdBtblEYGbXLViqoTqMp

☐ 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)

VjdfWcqhnPSunMDfKLNkpetsqCyUjlINjxZMiaCkWmYZJlHjhOmYhAtoOTfEzyrwpmRLmZgBhyalKcIZFwuAccHrxNAJrEYNOPbGCEaPHXIcrLhlecNRaWbscgAposlJlosCXQgeHCYpdOaoLbBJMODhsBsYxlJFrloqtfMGjDalITNZGmXgqopMGiOjrccWQupWPswY

An issuer needing more information may call the requesting provider directly at: +17412955711