TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

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SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:
Price Group	+13473777644	+14507246733	11/12/2015

SECTION II — GENERAL INFORMATION

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	LDwoqdZzQdsZgjoWPDaNygSHm	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	0-334-36919-3	

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☑ Other ☐ Unknown
Timothy Murphy	+10420296149	09/29/2005	

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Adriana Schroeder	68927191644	978-1-65600-745-2

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name: Calk Banks, NP		Name: Dr. Peter Pan, MD	
NPI #: 1183102420	Specialty: Internal Medicine	NPI #: 8001662939	Specialty: Anatomic
Phone: +17136928432	Fax: +17085985417	Phone: +10348511968	Fax: +16300569712
Contact Name: Dr. Peter Pan, MD	Phone: +16509215454	Primary Care Provider Name (see instructions): Rocha-Bell	
Requesting Provider's Signature and Date (if required): 08/03/2012		Phone: +12434258342	Fax: +15634091843

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
PSA screening - G0103		09/09/2020	01/09/2021	Corrosion of first degree of hip an - T24.5	
X-ray exam of thoracic spine - 72072		04/17/2001	07/01/2001	Cyst of spleen - D73.4	
Mr angiography neck w/dye - 70548		05/14/1995	12/04/1995	Sacrococcygeal disorders, not elsew - M53.3	
Brachytx, stranded, P-103 - C2640		09/13/1998	10/19/1998	Nutritional deficiency, unspecified - E63.9	

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

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

Number of Sessions: 20 Duration: 30 minutes Frequency: yearly Other: hFUlEVEwsxrcuLEXdNuB

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

Number of Visits: 19 Duration: 45 minutes Frequency: daily Other: wGIIXfOVgEUzuryWLfGz

☑ DME (MD Signed Order Attached? ☐ Yes ☑ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☑ No)

Equipment/Supplies (include any HCPCS Codes): E0730 - Transcutaneous electrical Duration: 45 minutes

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

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oXQTEJXdtJlGdnvMirwjOMKXdKbyBahqjDXLwzTNdEXOeHQGRbgVxqbbPLKEjckAcuVJmkfGAsCuMFRkiVRjGSD
VDEyaSALFEnlQCLtyWgjoUZf

An issuer needing more information may call the requesting provider directly at: +16509215454