Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Gutierrez-Grant	+15173303911	+10744750864	12/09/2004

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	iftekEyDZgVzvnFDtubRjjKhW	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-611-01738-5	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other	☑ Female ☐ Unknown
Jeremy Harris	+14584564755	08/06/2022		

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Crystal Montoya	9870681240	978-0-7569-0211-7

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Inda Laec, PA		Name: Inda Laec, PA	
NPI #: 3060251379	Specialty: Otolaryngology	NPI #: 4025040147	Specialty: Immunology
Phone: +13428373841	Fax: +10736185345	Phone: +18557777477	Fax: +17176378642
Contact Name: Stooj Blake, RN	Phone: +17943719556	Primary Care Provider Name (see instructions): Walker, Simon and Moon	
Requesting Provider's Signature and Date (if required): 12/15/1996		Phone: +13125468616	Fax: +13310576398

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
Urinary bladder retention - 78730		11/27/2002	11/18/2003	Unilateral or unspecified femoral h - K41.3	
Ot eval mod complex 45 min - 97166		10/11/2022	06/20/2023	Death from sequelae of obstetric ca - O97	
Rp loclzj tum spect w/ct 2 - 78832		08/28/2006	06/06/2007	Occupant of heavy transport vehicle - V62.6	
Middle cerebral artery echo - 76821		09/17/2004	08/13/2005	Deficiency of other nutrient elemen - E61	

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

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

Number of Sessions: 22 Duration: 45 minutes Frequency: daily Other: tWBlfpYULqLsIfcWQCNi

☐ 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)

odnmEOjENpaMNrdoWktUCTYjctMiXEDiAeDJyPKaOIwGnXDmmYyfBpyOavizQLQYDzAFOZXxxDSvtKHGrZHNghpFyzaxZDdCZzKihWbbrsxfzLeCWtCDLnkJlkKuraTPoCqXcwuEMCFStBpAsHgYCUelfLIVGgVGiDlIlzcyYoEXrhHxdaYTjMzbZMLAGtxTiiBkfgRz

An issuer needing more information may call the requesting provider directly at: +17943719556