

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Clear Form Print

Issuer Name: Lewis-Nguyen	Phone: 19775254110	Fax: 11123882285	Date: 06/07/2017
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SECTION II — GENERAL INFORMATION

Review Type: <input checked="" type="checkbox"/> Non-Urgent <input checked="" type="checkbox"/> Urgent	Clinical Reason for Urgency: ejxzhOuXCzJpajJSJrVjgEnGR
Request Type: <input checked="" type="checkbox"/> Initial Request <input checked="" type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #: 1-369-09996-7

SECTION III — PATIENT INFORMATION

Name: Bridget Miller	Phone: 19551166144	DOB: 10/23/1984	<input checked="" type="checkbox"/> Male <input checked="" type="checkbox"/> Female <input checked="" type="checkbox"/> Other <input checked="" type="checkbox"/> Unknown
Subscriber Name (if different): Katrina Dominguez	Member or Medicaid ID #: 60956466555	Group #: 978-1-74516-827-9	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Ltoen Klak, MD		Name: Inda Laec, PA	
NPI #: 2517932737	Specialty: Anesthesiology	NPI #: 3863823350	Specialty: Neurological Surgery
Phone: 11227141945	Fax: 14801745962	Phone: 10672096568	Fax: 12441600016
Contact Name: Inda Laec, PA	Phone: 15590875408	Primary Care Provider Name (see instructions): Griffin, Fields and Warren	
Requesting Provider's Signature and Date (if required): 06/08/2015		Phone: 13912124526	Fax: 13415475319

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
Cad cxr remote - 0175T		07/30/2021	01/01/2022	Contusion of thorax - S20.2	
Vol reduction of blood/prod - 86960		08/13/2002	12/20/2002	Benign lipomatous neoplasm of skin - D17.2	
Radiation treatment delivery - G6009		02/11/2016	10/10/2016	Other histiocytosis syndromes - D76.3	
Use 1st target lesion - 76982		08/05/1997	09/07/1997	Other pulmonary valve disorders - I37.8	
<input checked="" type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input checked="" type="checkbox"/> Provider Office <input checked="" type="checkbox"/> Observation <input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/> Day Surgery <input checked="" type="checkbox"/> Other: other					
<input checked="" type="checkbox"/> Physical Therapy <input checked="" type="checkbox"/> Occupational Therapy <input checked="" type="checkbox"/> Speech Therapy <input checked="" type="checkbox"/> Cardiac Rehab <input checked="" type="checkbox"/> Mental Health/Substance Abuse					
Number of Sessions: 7 Duration: 10 days Frequency: yearly Other: VZTibyGCfmEGYVRRkLaS					
<input checked="" type="checkbox"/> Home Health (MD Signed Order Attached? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No) (Nursing Assessment Attached? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No)					
Number of Visits: 12 Duration: 15 min. Frequency: weekly Other: other					
<input checked="" type="checkbox"/> DME (MD Signed Order Attached? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No) (Medicaid Only: Title 19 Certification Attached? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No)					
Equipment/Supplies (include any HCPCS Codes): bath stool Duration: 12 weeks					

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

xnHEhAtmFWDJGvibpkAgCyxenHMKoOgFXXFJmIbxpOPEZRPurxsngRyMDtQgsMasSaWDamXeswcaofEeAgfQacrERqjgATmhxrnbxxwAuLqkBqyWGALFAOkTvqmsbwQdzNjSFxKwpxzaxqNxMavILTuyqiAYbhgWrqnWkoZRpUuzc jLsuqppVQrdyAWMbqMhFUnJHznqh

An issuer needing more information may call the requesting provider directly at: 15590875408