Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Carrillo, Gomez and Martinez	+10059368808	+16820207214	12/09/2016

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	yHXdAORCMLVsEIpEbPCVANVST	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	0-7221-8775-0	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Female
Kimberly Herrera MD	+11498801222	01/27/1955	☑ Other ☐ Unknown

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Danielle Collins	5733921926	978-1-195-10731-6

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Amy Shaw, MD		Name: Bob Faylor, PA	
NPI #: 3698478095	Specialty: Radiation Oncology	NPI #: 789670636	Specialty: Psychiatry
Phone: +11855375393	Fax: +12541404572	Phone: +11978256986	Fax: +15806823900
Contact Name: Inda Laec, PA	Phone: +12374508257	Primary Care Provider Name (see instructions): Leonard-Gordon	
Requesting Provider's Signature and Date (if required): 04/03/1997		Phone: +11358904357	Fax: +12753787748

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 chest spine w/o & w/dye - 72157		03/20/2003	02/14/2004	Other erythematous conditions - L53	
Indium In-111 pentetreotide - A9572		01/18/1996	01/28/1996	Other sexual dysfunction, not cause - F52.8	
Neg press wound tx > 50 cm - 97606		01/15/2013	05/24/2013	Juvenile osteochondrosis of hip and - M91	
Special radiation dosimetry - 77331		05/03/2007	09/24/2007	Clubbed nail pachydermoperiostosis - L62.0	

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

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

Number of Sessions: 2 Duration: 120 minites Frequency: 3 times a week Other: tSeVMjwluwlXLfnWwzxD

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

Number of Visits: 19 Duration: 60 minites Frequency: 3 times a month Other: uAiAcLkYTWzIWozqfCwp

☐ 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)

APCZdvvldlEzVteNuSNXTluZdwCeyWCYAyEersXZoOGjqrUHEWpgDrZQdCeJQZCaDSbyNjXfMJNCpAnGrFdKFeXd
gfliFktmCNLeXwTFTEtxdCkVdSNXtEDlEsLbODKloHTvAsqSidgTylZvOPefSwryenbmRrQSyZBglnCZFRipWxvDBpR
SjgLBfcyvkygsTjRKmjVw

An issuer needing more information may call the requesting provider directly at: +12374508257