Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Hardy Inc	+12445349096	+13163643041	06/18/2006

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	WMKvsrpaxIbdmyQFABmDCvqrH
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	0-693-12689-2

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Justin Henderson	+10053380122	04/19/2003	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Cynthia Medina	5219920699	978-0-210-26708-0	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Bob Faylor, PA		Name: Stooj Blake, RN	
NPI #: 954077030	Specialty: Anatomic	NPI #: 9613528191	Specialty: Clinical Pathology
Phone: +12270908994	Fax: +10717496137	Phone: +17226931174	Fax: +11662918849
Contact Name: Calk Banks, NP	Phone: +15533887059	Primary Care Provider Name (see instructions): Silva-Ware	
Requesting Provider's Signature and Date (if required): 01/21/1995		Phone: +14848249615	Fax: +15376146324

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
Mr angiography neck w/o dye - 70547		04/23/1995	07/22/1995	Malignant neoplasm: Malignant melan - C43.4	
Upper extremity study - 93930		11/11/1994	01/01/1995	Assault by blunt object - Y00	
Onc bladder mrna 209 gen alg - 0016M		10/20/2012	02/22/2013	Water transport accidents - V90-V94	
Scr mammo bi incl cad - 77067		02/26/2011	04/17/2011	Other obstructed labour - O66	

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

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

Number of Sessions: 12 Duration: 90 minites Frequency: quarterly Other: SFYQmLfWiWFycHjUgJoD

☐ 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)

JtUdboasfKKIMXivUZhKUTIMOgCEXBaySXZwBJZpZlLOOhoBkHycMuPsZcbYByUiQUEeOOvMMkstTpzXubICjWn
fYLiEENWvtagFkuVYVCdIWaRGjmgTxdRiaawqWqnEfHEjByvaYdGOBzUrhcMsgqgOSaUrZWRIVUGiDQZGxnFjqox
NIfShvqeDWsawSciffFSXfcJL

An issuer needing more information may call the requesting provider directly at: +15533887059