Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Young PLC	+17099318283	+16855093945	08/31/2011

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	qlxmIldzyjpCQpJMCKGSidmge	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	1-56378-229-4	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☑ Female ☐ Other ☐ Unknown
Lori Mendoza	+10815701728	07/12/1998	
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	
Laura Lee	87577992975	978-0-7751-4641-7	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Calk Banks, NP		Name: Inda Laec, PA	
NPI #: 7898465165	Specialty: Rehabilitation	NPI #: 237458669	Specialty: Medical Genetics
Phone: +13065973009	Fax: +10291911171	Phone: +13574590003	Fax: +19893896096
Contact Name: Inda Laec, PA	Phone: +17004888152	Primary Care Provider Name (see instructions): Baldwin, Anderson and Rogers	
Requesting Provider's Signature and Date (if required): 03/19/2006		Phone: +19280292528	Fax: +17819030606

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
X-ray stress view - 77071		10/03/2005	08/01/2006	Small plaque parapsoriasis - L41.3	
Fluciclovine f-18 - A9588		08/09/2005	06/16/2006	Sequelae of inflammatory diseases o - G09	
Tc99m sestamibi - A9500		12/17/1996	08/30/1997	Rickettsial vaccines - Y59.1	
Us trgt dyn mbubb ea addl - 76979		12/06/2009	08/27/2010	Other and unspecified speech distur - R47.8	

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

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

Number of Sessions: 3 Duration: 120 minites Frequency: monthly Other: TIytFjZQAcbHDvjQIdNK

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

Number of Visits: 14 Duration: 90 minites Frequency: biweekly Other: TmsMnKcCERefUeYNKAKB

☐ 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)

scOeUXasGIwoVAMQWNFoMVDPeDEUuUzbxQhBZBIanaqvwRYsIxfUqujZDInVJeaSiYafazbaXrcYzHbESmQcGCCK
FLVoFySQVJwZlYtsNGpXYdtHvQmlMoErPIVrLDKsOLzhvrquQYJTjqLaNLGaJZzfFLueAWMtQOYtHtpnSoBVxhdPQ
ZmSGbnxAOTKBmBLuNHgHVnH

An issuer needing more information may call the requesting provider directly at: +17004888152