Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Snyder Ltd	+17527193757	+17748341722	07/21/2011

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	rPGtQAdfQibQPapubtMVhXdzL	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-274-01246-4	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Christina Pearson	+17994384442	06/06/1992	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Erin Contreras	21940065890	978-1-00-061856-3	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Amy Shaw, MD		Name: Inda Laec, PA	
NPI #: 524076718	Specialty: Dermatology	NPI #: 8766790213	Specialty: Neurology
Phone: +19945885873	Fax: +12237133139	Phone: +17869169411	Fax: +12828863943
Contact Name: Calk Banks, NP	Phone: +18799785088	Primary Care Provider Name (see instructions): Weber LLC	
Requesting Provider's Signature and Date (if required): 04/07/1998		Phone: +19195719668	Fax: +16227966274

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
Contrast bath therapy - 97034		03/09/2002	01/28/2003	Supraventricular tachycardia - I47.1	
X-ray exam of eye sockets - 70200		04/05/2010	11/12/2010	Cardiovascular disorders in other i - I98.1	
Urinary bladder retention - 78730		06/05/2012	06/08/2012	Pedal cyclist injured in collision - V14.3	
Contrast x-ray gallbladder - 74290		10/22/2011	03/12/2012	Burn and corrosion of respiratory t - T27	

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

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

Number of Sessions: 24 Duration: 60 minites Frequency: 2 times a week Other: DSAvBojUXhJtfbUNGlsv

☐ 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): E0431 - Portable gaseous oxygen s Duration: 150 minites

Section VI — Clinical Documentation (See Instructions Page, Section VI)

pdFisiOABWgAFfSGsRbDzNbqHnpAbZjvOYBOvbcfouAhScjmimwNwHqgYAbZEtJgOQSbPIBZvKWyvWLFKMWFUh
hRGXqusPGRgLvVkAgTTGlstIrJboJjMKarpGoSvFQSzqkNhNfjTlSguJSEKWdtEmKFgfzdzGxsCnEJIolkSMiVfmjvmPT
njEyuwPZZsSgLSOTtlSyu

An issuer needing more information may call the requesting provider directly at: +18799785088