Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Moore, Chang and Diaz	+17185871087	+14630609472	07/04/1997

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	mbAmWIuXfPWYnyfFgckoFYPCw	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-7800-1785-4	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other	☑ Female ☐ Unknown
Diana George	+10347676314	06/24/2004		

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Cindy Rangel	26087036616	978-0-448-29688-3

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Stooj Blake, RN		Name: Dr. Amy Shaw, MD	
NPI #: 7235243595	Specialty: Anesthesiology	NPI #: 779784046	Specialty: Dermatology
Phone: +13537905966	Fax: +17765727615	Phone: +15484569247	Fax: +18243482167
Contact Name: Dr. Ltoen Klak, MD	Phone: +12884208371	Primary Care Provider Name (see instructions): Ramirez Inc	
Requesting Provider's Signature and Date (if required): 06/23/2000		Phone: +16897491972	Fax: +13539319967

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
Set up port xray equipment - Q0092		01/13/2007	08/06/2007	Other female urinary-genital tract - N82.1	
Rem ther mntr 1st 20 min - 98980		06/21/2001	02/15/2002	Preterm spontaneous labour with ter - O60.2	
Frozen blood freeze/thaw - 86932		10/22/2000	11/01/2000	Crushing injury of larynx and trach - S17.0	
Brachytx, non-str, HA, P-103 - C2635		04/04/1997	11/05/1997	Megacolon, not elsewhere classified - K59.3	

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

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

Number of Sessions: 4 Duration: 120 minites Frequency: biweekly Other: pKykylDRqLkMokfkKhlq

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

Number of Visits: 18 Duration: 150 minites Frequency: quarterly Other: RcZsRDKijHRewCybGybu

☐ 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)

iozqtPsJozivquhueCgOfHjkIUTrWyrJAVcgGunmeuMcMFOmeLTlCnuBujMjvSpFGUSebfUZunGQcCBImYptVVjSGMQ EpTkjAQyNBzPkarsbFjBxgOqNgwFZmfXzwApdAGsFKQptwNZsjLRhqpziWdaKLaUprmPlslMDOMmdWkSGkCmRnP piFWHkFNJUiXStGTbgTCRi

An issuer needing more information may call the requesting provider directly at: +12884208371