Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Young-Weber	+12711821233	+15541846341	10/15/2013

Section II — General Information

Review Type: ☐ Non-Urgent ☑ Urgent	Clinical Reason for Urgency:	qcXjZPaRZfnwVzfuliHvokEkI	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	1-84878-629-8	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☑ Female ☐ Other ☐ Unknown
Kelly Larson MD	+12456849022	06/07/1999	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Amy Guerra	47426501705	978-1-198-38422-6	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Stooj Blake, RN		Name: Inda Laec, PA	
NPI #: 5428488168	Specialty: Pathology	NPI #: 7227564793	Specialty: Orthopedic Surgery
Phone: +16681597092	Fax: +13519193579	Phone: +10615021243	Fax: +16138088841
Contact Name: Dr. Peter Pan, MD	Phone: +19727178624	Primary Care Provider Name (see instructions): Moody, Lopez and James	
Requesting Provider's Signature and Date (if required): 10/09/2010		Phone: +16038026923	Fax: +17990169854

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
Speech/hearing therapy - 92508		12/01/2000	09/11/2001	Cerebral arteritis in other disease - I68.2	
X-ray exam of foot - 73620		04/08/2018	08/09/2018	Other chondrocalcinosis - M11.2	
Mr angio pelvis w/o & w/dye - 72198		05/09/2009	09/21/2009	Other forms of leptospirosis - A27.8	
Design mlc device for imrt - 77338		09/26/1998	12/28/1998	Personal history of allergy to peni - Z88.0	

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

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

Number of Sessions: 21 Duration: 120 minites Frequency: 3 times a month Other: FVrmIOPquTbfolRVnYDg

☐ 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)

wUmLqYigIVWyXzDXqfhTFtWtERuFCKzHAZCiqPUvRaUZMnBjWzmUfvOCVqxDYeIKzFoCubLehzxspKTSZrDsveTzcQyTcLytzoNnncsWCSuePDinhMHzZljyBmsxBEhXWHeUTigskgkHzGYjcmaBPSbGZnYGiLtzMvOUyesNajPsRFKhRVGAbKapfXHWKSQsupCkYTsL

An issuer needing more information may call the requesting provider directly at: +19727178624