Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Griffin, Snow and Nelson	+10912075642	+15055755109	12/26/2000

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	eIhtenPSsCqEccvVMRuWkwVxk	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-444-81456-6	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other	☑ Female ☐ Unknown
Tonya Hill	+15622399787	03/18/1986		
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:		
Kyle Maldonado	48486176737	978-1-00-755221-1		

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Inda Laec, PA		Name: Calk Banks, NP	
NPI #: 6405853284	Specialty: Immunology	NPI #: 681308280	Specialty: Neurology
Phone: +16170555677	Fax: +19917428114	Phone: +15472037994	Fax: +19167243145
Contact Name: Dr. Amy Shaw, MD	Phone: +16329819892	Primary Care Provider Name (see instructions): Ritter Inc	
Requesting Provider's Signature and Date (if required): 10/11/2013		Phone: +14531823715	Fax: +19153086643

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 head w/dye - 70545		06/17/2022	05/19/2023	Dengue, unspecified - A97.9	
Hematopoietic nuclear tx - 79403		06/28/2002	01/16/2003	Mixed cortical and subcortical vasc - F01.3	
Physical medicine procedure - 97799		08/01/2012	05/11/2013	Other benign neoplasm: Corpus uteri - D26.1	
Sm 153 lexidronam - A9604		06/09/2006	02/04/2007	Genital varices in pregnancy - O22.1	

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

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

Number of Sessions: 17 Duration: 150 minites Frequency: biweekly Other: IhdBboRfyLQxuFvmTcbX

☐ 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)

nzqoSwAKRfaFhwacHXGJvINRfiRNnbtISJqOaxGvQirNQMwXKekmqfhjjvxjfBkTIMeNgVuvNkKVMsxQKSDTcuuLohkyyDkrlWJxsoJJrIljSquuincTtyztNLJMSXlRmUYGLhMfQHTVmDQvMVVTkJDxiKoQlkdGhMfKvCLpuNSJSsueMlBCcQqLhXLgnskRcMDnXKyH

An issuer needing more information may call the requesting provider directly at: +16329819892