Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Martinez PLC	+16112819461	+10075290155	01/21/2017

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	IJOdEEtYIMRTkLfEqQdBPKbQC	
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment	Prev. Auth. #:	0-433-15356-3	

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Kevin Cole	+19244325215	09/04/1962	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Hannah Freeman	2299882168	978-0-903116-91-6	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Peter Pan, MD		Name: Dr. Peter Pan, MD	
NPI #: 4060590481	Specialty: Physical Medicine	NPI #: 8646971287	Specialty: Plastic Surgery
Phone: +11705871033	Fax: +14447667264	Phone: +16862294924	Fax: +18181709475
Contact Name: Dr. Ltoen Klak, MD	Phone: +17551430341	Primary Care Provider Name (see instructions): Johnson-Wilson	
Requesting Provider's Signature and Date (if required): 06/12/2019		Phone: +13693901899	Fax: +13240093657

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
Prosthetic trainj 1st enc - 97761		05/22/1996	09/17/1996	Other and unspecified abnormalities -	R00.8
Us exam abdom complete - 76700		08/29/2007	06/20/2008	Other congenital malformation syndr -	Q87.5
Rx mntr lc-ms/ms ur 31 pnl - 0051U		07/18/2021	10/14/2021	Nonrheumatic tricuspid (valve) sten -	I36.2
Special teletx port plan - 77321		07/21/1993	05/04/1994	Female pseudohermaphroditism, not e -	Q56.2

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

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

Number of Sessions: 25 Duration: 90 minites Frequency: 3 times a month Other: YSkUuwAvMtCNjOGGNomT

☐ 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)

uVPwyzfgzhihJsnufxJLqffOscXsukVxczZZWULyLbuJHxHFnTjnrvTMPuzmvXEtoKEphCkPaRCMyBUalkEbxKaofASCilVdmeJWzlGqXSivEcCClkDGYbZsNkeDqTmKMFYOrFwXxZVymSwxmzgkfoRbMVmvfYnKlVnytKGYUosqNWMFVYhxnDGpnNXZZYlCljVrlJpu

An issuer needing more information may call the requesting provider directly at: +17551430341