Texas Standard Prior Authorization Request Form for Health Care Services

Clear Form | Print

Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Johnson Ltd	+13869871320	+13308500994	10/26/2012

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	kEMkbgRwnozWEJThUGJsphekq
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	0-472-72616-1

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☑ Unknown
Scott Zhang	+12770048454	06/10/1961	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Anthony Marquez	58591488215	978-0-567-57544-9	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Calk Banks, NP		Name: Bob Faylor, PA	
NPI #: 516717700	Specialty: OBGYN	NPI #: 3917806697	Specialty: OBGYN
Phone: +13174155777	Fax: +10317931872	Phone: +13398079520	Fax: +14117161016
Contact Name: Dr. Peter Pan, MD	Phone: +13362411513	Primary Care Provider Name (see instructions): Clark-Cruz	
Requesting Provider's Signature and Date (if required): 08/20/1996		Phone: +10227091840	Fax: +14901480603

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
Glucose tolerance test (GTT) [only - 82951		01/26/2020	10/16/2020	Malformation of placenta - O43.1	
U/s trtmt, not leiomyomata - C9734		12/25/1992	12/03/1993	Rheumatic tricuspid valve diseases - I07	
Ob us detailed sngl fetus - 76811		11/01/1999	06/23/2000	Pedestrian injured in collision wit - V01.9	
X-ray exam of hand - 73130		02/09/2015	10/01/2015	Caries with pulp exposure - K02.5	

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

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

Number of Sessions: 22 Duration: 120 minites Frequency: daily Other: cnCnEpOWJVnRoLEpcAfb

☐ 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)

efAuOxgaoVtuJaxdTUMQjpYRUryLMYcOEARyRDELeYJXOtuLSpWpIdleSRsMTVcunpRyhAHYNkXBIsatgCpMYBbZdlbplHtrYFKsusnMirDOuPNtqaeiuvcasLIyPpiMfYcdUPzVGfyLoZzUppczOFnMeGDKDqyqixgdkkKSSEegorjrtaIUnWAaPbzUKlwDdQTHEKwO

An issuer needing more information may call the requesting provider directly at: +13362411513