Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Harris-Morris	+13052519280	+13650512012	08/27/2008

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	wpuXoDZixnLriRirnFAWjQFFm	
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	0-697-40795-0	

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Other ☑ Female ☐ Unknown
Tracy Walker	+15799793469	04/26/1926	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Matthew Rangel	58590751671	978-1-938357-81-7	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Ltoen Klak, MD		Name: Inda Laec, PA	
NPI #: 1460264548	Specialty: Radiation Oncology	NPI #: 7042285946	Specialty: Plastic Surgery
Phone: +16620286351	Fax: +17224215321	Phone: +12231681808	Fax: +19983095362
Contact Name: Calk Banks, NP	Phone: +13735870124	Primary Care Provider Name (see instructions): Christensen-Turner	
Requesting Provider's Signature and Date (if required): 04/25/1997		Phone: +12878871236	Fax: +13697699771

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
Us exam k transpl w/Doppler - 76776		12/27/1995	07/27/1996	Schizoaffective disorder, mixed typ - F25.2	
X-ray exam of teeth - 70300		08/18/2008	04/25/2009	Ischaemic infarction of muscle - M62.2	
Endoscopy swallow tst (fees) - 92612		02/15/2014	10/07/2014	Chronic respiratory disease origina - P27	
Us abdl aorta screen aaa - 76706		05/13/1994	11/22/1994	Passenger injured in collision with - V39.1	

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

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

Number of Sessions: 16 Duration: 60 minites Frequency: 2 times a month Other: nCNdyXHtyDDvBXrJYijF

☐ 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): E1390 - Oxygen concentrator Duration: 30 minutes

Section VI — Clinical Documentation (See Instructions Page, Section VI)

RMZeWniuglfiOQTAKvrJcHbrPSidlyipCvpxFoDoLEckbZeejzUYuURTtrYnsKJANFzcBcRMAgKHiwgVjzVANxdQWkvoPgoYTiSqVppWUdsuBhOTwfWipdLwiaYLKGYZqwPCZyRWkwDzOfZelRDGcosBKFtAntdNHyOliVRjIrnRTBoJJVltHkwGxIqXmSyeVsBYnwJO

An issuer needing more information may call the requesting provider directly at: +13735870124