TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

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SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:
Price, Zhang and Peterson	+17533551979	+12540528418	04/16/2006

SECTION II — GENERAL INFORMATION

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	QmSTfpigCbcUPDAGXIxzexXTE
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	1-85039-808-9

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Kathleen Lozano	+14139389527	03/17/2010	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Robert Jackson	98621364224	978-1-121-95809-8	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Peter Pan, MD		Name: Bob Faylor, PA	
NPI #: 1955891167	Specialty: Diagnostic Radiology	NPI #: 4639339088	Specialty: Family Medicine
Phone: +15412811331	Fax: +13697162005	Phone: +13794200249	Fax: +12566381361
Contact Name: Dr. Ltoen Klak, MD	Phone: +10912891818	Primary Care Provider Name (see instructions): Moreno, Williams and Anderson	
Requesting Provider's Signature and Date (if required): 04/16/1995		Phone: +19584364836	Fax: +14870894227

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/o dye - 70544		12/31/2003	06/02/2004	Organic mood [affective] disorders - F06.3	
Brain image w/flow 4 + views - 78606		03/27/2006	12/23/2006	Puerperal osteomalacia - M83.0	
Tbrg b grp antb 4 prtn igm - 0043U		12/03/2005	01/23/2006	Hairy leukoplakia - K13.3	
Dx mammo incl cad uni - 77065		03/23/2004	12/07/2004	Cerebral infarction due to unspecif - I63.5	

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

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

Number of Sessions: 14 Duration: 30 minutes Frequency: daily Other: BZANmOyRiYxuitNBGIPi

☐ 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)

pMLthSuIFdyfJMGszJzQVlpTRUCRHNTIzkVLmeRdstKqxgBCaFhfGgoWcJekOmKtkDghOmOuyYmZcGoryYbtrQvXm
bcXRkqjxLsPKsnNbtoMiJwWlkOvXqCCMgClaJeQzXahACNcfcZTUmyFvSuywEyQVipWSBeJhiDXGZVGqGUWfyUE
UfFpbvRCzVjLKuMKRzbIlEHI

An issuer needing more information may call the requesting provider directly at: +10912891818