Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Cross-Sweeney	+18101758303	+11823139405	10/22/1996

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	RfxGCinoojpMpsiIOUlINmtSE
Request Type: ☐ Initial Request ☑ Extension/Renewal/Amendment		Prev. Auth. #:	0-693-67665-5

Section III — Patient Information

Name:	Phone:	DOB:	☑ Male ☐ Female ☐ Other ☐ Unknown
Madison Roberts	+17143340608	07/03/1939	
Subscriber Name (if different):	**Member or Medicaid ID #:**	**Group #:**	
Jordan Miller	77536920498	978-0-227-31054-0	

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Bob Faylor, PA		Name: Dr. Ltoen Klak, MD	
NPI #: 2911761190	Specialty: Pediatrics	NPI #: 811655064	Specialty: General Surgery
Phone: +11513366013	Fax: +16915661844	Phone: +17254784221	Fax: +15790046609
Contact Name: Stooj Blake, RN	Phone: +19136262728	Primary Care Provider Name (see instructions): Allen-Thompson	
Requesting Provider's Signature and Date (if required): 03/24/2005		Phone: +17955811429	Fax: +17609148568

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
PET image skull-thigh - 78812		11/02/1995	07/26/1996	Malignant neoplasm: Vallecula - C10.0	
Echo guidance radiotherapy - G6001		11/17/2002	12/12/2002	Other congenital valgus deformities - Q66.6	
Gastric mucosa imaging - 78261		02/08/2010	11/17/2010	Preparatory care for dialysis - Z49.0	
IIV3 vacc no prsv 0.5 ml im - 90656		08/27/1996	04/04/1997	Unspecified congenital malformation - Q74.9	

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

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

Number of Sessions: 5 Duration: 90 minites Frequency: 3 times a week Other: FbdjAhjotyNKAfahUANL

☐ 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)

xywkNGGxlZlqsTRHgSFggXpyOBwDexYaRmbZExiehpXosqLqfnLvMgtFwIwMnnuBFpwTPZmzpAFcfnLgUfvTBsAun
ENWMqgCaxpaofjFjKVzuTAbhXTOAMDmfNUnRFIIIiNuuRXRAKqOaBaQrbeMSuMbhgNiQXZuayiMQSxjwCfvaPkW
DRyNiwICTedAiFeKgMYniwAe

An issuer needing more information may call the requesting provider directly at: +19136262728