Texas Standard Prior Authorization Request Form for Health Care Services

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Section I — Submission

Issuer Name:	Phone:	Fax:	Date:
Reed and Sons	+19198559659	+16537599672	09/30/2018

Section II — General Information

Review Type: ☑ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	NOrOKmqoOvGyaJybhscanayvO
Request Type: ☑ Initial Request ☐ Extension/Renewal/Amendment		Prev. Auth. #:	1-76940-210-1

Section III — Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Female
Willie Ferguson	+19111622280	03/14/1946	☑ Other ☐ Unknown

Subscriber Name (if different):	Member or Medicaid ID #:	Group #:
Zachary Bauer	6291889467	978-0-07-456218-5

Section IV — Provider Information

Requesting Provider or Facility		Service Provider or Facility	
Name: Dr. Ltoen Klak, MD		Name: Stooj Blake, RN	
NPI #: 3533530907	Specialty: Anesthesiology	NPI #: 3648070737	Specialty: Neurological Surgery
Phone: +18763814872	Fax: +14372183001	Phone: +11259075387	Fax: +18018693068
Contact Name: Bob Faylor, PA	Phone: +11789530171	Primary Care Provider Name (see instructions): Davis and Sons	
Requesting Provider's Signature and Date (if required): 12/29/2018		Phone: +19861890738	Fax: +11358847891

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
Cmptr ophth img optic nerve - 92133		08/09/2009	02/01/2010	Traumatic rupture of ulnar collater - S53.3	
Ct thorax dx c+ - 71260		11/14/2001	12/22/2001	Artificial insemination - Z31.1	
Place breast cath for rad - 19297		02/04/1993	04/30/1993	Failure to introduce or to remove o - Y65.4	
RIV3 vaccine no preserv im - 90673		10/11/1995	07/27/1996	Contact with marine animal - W56	

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

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

Number of Sessions: 8 Duration: 45 minutes Frequency: quarterly Other: ILCjLsTKdZYfrIvTzdVl

☐ 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)

EzDzlXLIdsftoAkPRXJyAuVfhaVVhEBgvaYfMKgWMruhrvzqhFfEbqODzdMQZVUYLnHnWzHwWfCXxwLgJwzJtdyJaXzsYALFqQoAfZFUGfVMkHGCbRuFiNkcDdhevvwIbvMaovmrelMMjltuswwZNueXZgTJRohRbMgcpDwxTRyUBSoHfDyLwqymlbSAkxaRtnbeKKkl

An issuer needing more information may call the requesting provider directly at: +11789530171