**Texas Standardized Prior Authorization Request Form For Health Care Services**

*Section I — Submission*

|  |  |  |  |
| --- | --- | --- | --- |
| Issuer Name | Phone  ( ) | Fax  ( ) | Date Submitted  / / |

*Section II — General Information*

|  |  |
| --- | --- |
| Review Type 🗆 Non Urgent 🗆 Urgent | Clinical reason for urgency |
| Request Type 🗆 Initial Request | 🗆 Extension/Renewal/Amendment (Prev. Auth. #: ) |

*Section III — Patient Information*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Patient Contact Phone  ( ) | DOB  / / | | Sex 🗆 Male 🗆 Female  🗆 Unknown |
| Subscriber Name (if different) | Member or Medicaid ID # | | Group # | |

*Section IV ― Provider Information*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Requesting Provider or Facility* | | *Service Provider or Facility* | | |
| Name | | Name | | |
| NPI # | Specialty | NPI # | | Specialty |
| Phone  ( ) | Fax  ( ) | Phone  ( ) | | Fax  ( ) |
| Contact Name and Phone | | Name of Primary Care Provider (see instructions) | | |
| Requesting Provider’s signature and date (if required) | | Phone  ( ) | Fax  ( ) | |

*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* |
|  |  | / / | / / |  |  |
|  |  | / / | / / |  |  |
|  |  | / / | / / |  |  |
|  |  | / / | / / |  |  |
| **🗆** Inpatient **🗆** Outpatient **🗆** Provider Office **🗆** Observation **🗆** Home **🗆** Day Surgery **🗆** Other (specify) | | | | | |
| **🗆** Physical Therapy **🗆** Occupational Therapy **🗆** Speech Therapy **🗆** Cardiac Rehab **🗆** Mental Health/Substance Abuse  Number of sessions Duration Frequency Other | | | | | |
| **🗆** Home Health (MD signed Order attached? **🗆** Yes **🗆** No) (Nursing Assessment attached? **🗆** Yes **🗆** No)  Number of visits requested 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)***

***An issuer needing more information may call the requesting provider directly at: (          ) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_ (ext. \_\_\_\_\_\_\_\_\_).***