Texas Standardized Prior Authorization Request Form For Health Care Services

Section I — Submission

HealthHelp	Phone 1-866-825-1550	Fax 1-888-863-4464	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. _____).