

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:
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SECTION II — GENERAL INFORMATION

Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency:
Request Type: <input type="checkbox"/> Initial Request <input type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #:

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
			<input type="checkbox"/> Other	<input type="checkbox"/> 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:	Phone:	Primary Care Provider Name (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

<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Provider Office <input type="checkbox"/> Observation <input type="checkbox"/> Home <input type="checkbox"/> Day Surgery <input type="checkbox"/> Other: _____
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Mental Health/Substance Abuse Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____
<input type="checkbox"/> Home Health (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Nursing Assessment Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____
<input type="checkbox"/> DME (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Medicaid Only: Title 19 Certification Attached? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

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Member's Name:

Member I.D.

Section VII. Identifying Information:			
Current Living Situation:	<input type="checkbox"/> With Parent(s)	Group/Foster Home	Other (list):

Section VIII. Court Ordered Service?	Yes	No
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Section IX. DFPS Directed Service:	Yes	No
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Section X. Psychiatric Medications:

Medication	Dose	Frequency	Prescribing Physician

Section XI. Continuation of Therapy Requests: Please indicate the following. (Complete all sections):

Current Symptoms:	
Response to Past Treatment: (Provide Detailed Information)	
Specific Therapeutic Interventions:	

Section XII. Short Term Measurable Treatment Goals: (Note specific progress for each goal)

Goal	Current Progress	Target Date

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Member Name _____ **Member I.D.** _____

Section XIII.

<u>Anxiety/Phobia</u>	<u>Risk Factors</u>	<u>Sleep Patterns</u>	<u>Eating Patterns</u>	<u>Substance Abuse</u>
Anxiety	Social Isolation	Hypersomnia	Increase Appetite	Alcohol
Panic Attack	Impaired Judgment	Insomnia	Decrease Appetite	Drugs
Phobic Responses	Aggression	Nightmares	Bulimia	Active
Excessive Worry	Oppositional/Defiant	Traumatic Dreams	Anorexia	Remission
PTSD	Self injurious	Hyposomnia		Withdrawal Symptoms

<u>Mood</u>	<u>Cognition</u>	<u>Thought Content</u>	<u>Functionality</u>	<u>Activity</u>
Anger	Decrease Concentration	Flight of Ideas	Obsessions/Compulsions	Decrease in Energy
Apathy	Distractibility	Loose Association	Hypersexual	Psychomotor Retardation
Blunted/Flat Affect	Impaired Abstract Thinking	Hyper-talkative	Impaired ability to function at:	Restlessness
Depressed Mood	Memory Impairment	Pressured Speech	Home	Hyperactivity
Elevated/Expansive	Difficulty Making Decisions	Racing Thoughts	School	Impulsiveness
Grandiosity	Hallucinations	Delusions	Work	
Hopelessness		Grandiosity	High Risk Behavior	
Irritable		Paranoid Ideation	Anti-Social Behavior	
Low Self Esteem				
Tearfulness				
Mood Swings				

Section XIV.

Suicidal: Yes No Explain: _____

Homicidal: Yes No Explain: _____

Emotional Trauma: Yes No Explain: _____

Sexual Trauma: Yes No Explain: _____

Physical Trauma: Yes No Explain: _____
