Texas Standardized Prior Authorization Request Form For Health Care Services Section I — Submission Issuer Name Phone Fax **Date Submitted** OrthoNet 1-800-862-4006 1-800-863-4061 Section II — General Information Review Type □ Non Urgent □ Urgent Clinical reason for urgency □ Extension/Renewal/Amendment (Prev. Auth. #: Request Type □ Initial Request 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# NPI# Specialty Specialty Phone Fax Phone Fax Contact Name and Phone Name of Primary Care Provider (see instructions) Requesting Provider's signature and date (if required) Section V — Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code) Start End Planned Service or Procedure Code Diagnosis Description (ICD Version ___ Code Date Date / / / / / / / / □ 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 ☐ Home Health (MD signed Order attached? ☐ Yes ☐ No) (Nursing Assessment attached? ☐ Yes ☐ No) Number of visits requested Duration Frequency

Section VI — Clinical Documentation (See Instructions Page, Section VI)

An issuer needing more information may call the requesting provider directly at: () ______ - _____ (ext. _____).

(*Medicaid only:* Title 19 Certification attached? □ Yes □ No)

Duration

 \square DME (MD signed order attached? \square Yes \square No)

Equipment/supplies (Include any HCPCS Codes)