

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I – SUBMISSION

Issuer Name: Memorial Hermann Health Solutions, Inc.	Phone: 713-338-6588	Fax: 713-338-6494	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: _____