TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

Issuer Name:	Phone:	Fax:	Date:
Superior HealthPlan	1-844-744-5315	1-866-469-0725	

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:	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: Fax:	
NPI #:		NPI #:	Specialty:
Specialty:		Phone:	
Phone:	Fax:	Primary Care Provider Name *(see instructions)*:	
Contact Name:	Phone:	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:_____

☐ 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:_____ 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)*

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An issuer needing more information may call the requesting provider directly at: _____

Requesting Physician's Signature:_____ Date: _____