Wee-Care Pediatric Home Health

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

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:	☐ Male Female ☐ Other Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name: Wee-Care Pediatric Home Health	
NPI #:	Specialty:	NPI #: 1505155181	Specialty:
Phone:	Fax:	Phone: 972-235-9155	Fax: 972-421-1833
Contact Name:	Phone:	Primary Care Provider Name (see instructions): SAME	
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: ________________

☐ 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)

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