PRIOR AUTHORIZATION FORM

Van Lang IPA
c/o TECQ Partners
8278 Bellaire Blvd., Ste. B; Houston TX 77036
- To accelerate processing of PA request, submit PA request to our portal at (payer.tecqpartners.com)
- Fax PA request to (+1-833-585-5298) [enter +1 or fax will fail]
Telephone No: (888) 319-0777 ext 699

(Sections A - C must be filled out completely. Failure to complete these sections will delay the approval process.)

SECTION A PATIENT INFORMATION

REFERRAL DATE: ___ / ____ / ____ **HEALTH PLAN** ☑ **Amerigroup / Anthem | SERVICE LINE** ☐ **Medicare Advantage**

SERVICE TYPE: ☑ Routine ☐ Urgent ☐ Retro

PATIENT / MEMBER NAME _____

DOB: _____/_____/_____ **GENDER:** ☐F ☐M **MEMBER ID:** _____

SECTION B PROVIDER INFORMATION

Please indicate whether the referral is to a participating or non-participating provider:

☐ **Participating Provider** ☑ **Non-Participating** (**NOTE**: Approval must be obtained **before appointment is scheduled**.)

REFERRED TO (PHYSICIAN/PROVIDER/FACILITY):

NAME: Acadian Ambulance Service of Texas

SPECIALTY: Ground ambulance

ADDRESS: 3720 Corley Ave. Beaumont, TX 77701

PHONE NO: (337) 521-3560

FAX NO: (337) 291-2271

REFERRING PHYSICIAN (PCP/PROVIDER):

PCP NAME: _____

ADDRESS: _____

PHONE NO: (_____)_____

FAX NO: (_____)_____

SECTION C REASON(S) FOR REFERRAL

Place of Service: ☐ **Inpatient** ☑ **Outpatient** ☐ **Office** **Facility Name:** Acadian Ambulance Service of Texas

ICD10-Code: _____ **ICD10-Code:** _____ **CPT CODE 1:** _____ **# of Visits** [ ] **CPT CODE 3:** _____ **# of Visits** [ ]

IDC10-Code: _____ **IDC10-Code:** _____ **CPT CODE 2:** _____ **# of Visits** [ ] **CPT CODE 4:** _____ **# of Visits** [ ]

IDC10-Code: _____ **IDC10-Code:** _____ **CPT CODE 5:** _____ **# of Visits** [ ] **CPT CODE 6:** _____ **# of Visits** [ ]

Accident?: ☐ **Yes** ☐ **No**

DX/Significant Reason(s) for Referral (Attach H&Ps, Progress Notes):

_____

PROVIDER SIGNATURE (PCP OR SPECIALIST): X _____ **DATE**_____

(Disclaimer: SIGNATURE REQUIRED or will be returned unprocessed. If signed by rubber stamp, you accept full responsibility/liability for request.).
Please submit your PA request via TECQ Partners payer system (payer.tecqpartners.com) or by faxing the request and all attached relevant documentation to + 1 – 833- 585 – 5298 [enter +1 or fax will fail].

For processing and Medical Review.

IMPORTANT INSTRUCTIONS: TO CONSULTING PROVIDERS AND PCPS. PLEASE READ CAREFULLY.

- **Physician Reviewer is available to discuss the outcome of this authorization at (888) 319-0777 ext 699**

Important Notice: Authorization Referral Form must include ICD-10 and CPT Codes; it will be returned for incompletion, delaying the approval process. **Documentation supporting medical necessity must accompany referral. If medical necessity cannot be established, referral may be denied.**

- **SPECIALIST:** If further diagnosis, therapeutic services or consults are indicated, contact the PCP for additional referral information and/or modification to services requested.
- This is not an authorization to admit the member to any inpatient facility. Please contact the PCP if hospitalization is needed. In the event eligibility has been terminated, this referral is no longer valid. **PROVIDERS SHOULD ALWAYS VERIFY ELIGIBILITY PRIOR TO RENDERING SERVICE(S) BY CALLING THE MEMBER'S HEALTH PLAN.**
- To insure prompt and accurate payment of your fees, attach one copy of this Authorization Referral Form and Progress Notes to your standard bill and send to the above address. **Do Not Bill The Patient/Member.**
- Your claim form must include the CPT Code with charges, DOS, and ICD-10 Diagnosis Code. **Incomplete Claims Will Be Deferred.**
- Services will be reimbursed according to the Provider Agreement, the patient's type of insurance coverage and/or UC&R. Rev 01.2018