TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:
Wellpoint (Formerly Amerivantage)	800-454-3730	866-959-1537	

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: Acadian Ambulance Service of Texas	
NPI #:	Specialty:	NPI #:1750676870	Specialty: Ambulance
Phone:	Fax:	Phone: 337-521-3560	Fax: 337-291-2271
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 10)	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: 337-521-3560