PRIOR AUTHORIZATION FORM

Van Lang IPA-TECQ Partners-TECQ Foundation

8278 Bellaire Blvd., Ste. B, Houston TX 77036, Telephone No: 1(888) 319-0777

TECQ Partners Portal at: payer.tecqpartners.com for direct PA submission and faster processing

Fax PA request to 1-833-585-5298 (enter +1 or fax will fail)

Note: Approval Must be Obtained Before Appointment is Scheduled

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

SECTION A **PATIENT INFORMATION**

Referral Date: ______/______/______
Service Type (Choose ONE): ☐ Routine ☐ Urgent ☐ Retro
If Retro: START Date of Service: ______/______/______

Patient/Member Name: ________________________________
Gender: ☐ F ☐ M
DOB: ______/______/______
Member ID: ________________________________

MEDICARE definition of URGENT is services furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.

SECTION B **PROVIDER INFORMATION**

To identify a participating Provider please go to: https://www.tecqfoundation.com

REQUESTING PHYSICIAN/PROVIDER/FACILITY	**REFERRING TO PHYSICIAN/PROVIDER/FACILITY**
NAME: ________________________	**NAME:** ________________________
SPECIALTY: ________________________	**SPECIALTY:** ________________________
ADDRESS: ________________________	**ADDRESS:** ________________________
PHONE: ________________________	**PHONE:** ________________________
FAX: ________________________	**FAX:** ________________________
NPI: ________________________	**NPI:** ________________________
TIN: ________________________	**TIN:** ________________________

PAs submitted without clinical information that is current and related to the specific requested service cannot be reviewed and will delay authorization while we work with your office to secure needed clinical information.

SECTION C **REASON(S) FOR REFERRAL**

Place of Service: ☐ Office ☐ Outpatient ☐ Inpatient **/If Inpt or Outpt Facility include Name:** ____________________________

ICD-10 code	CPT code	Qty	Check Unit Type	CPT code	Qty	Check Unit Type
________	________	☐	Units ☐ Visits ☐	________	☐	Units ☐ Visits ☐
________	________	☐	Units ☐ Visits ☐	________	☐	Units ☐ Visits ☐
________	________	☐	Units ☐ Visits ☐	________	☐	Units ☐ Visits ☐
________	________	☐	Units ☐ Visits ☐	________	☐	Units ☐ Visits ☐
________	________	☐	Units ☐ Visits ☐	________	☐	Units ☐ Visits ☐

Important Notice: Authorization Referral Form must include ICD-10 and CPT Codes; it will be returned for completion of the required information and will delay the approval process. **Documentation supporting medical necessity must accompany referral. If medical necessity cannot be established, referral may be denied. Physician Reviewer is available to discuss the outcome of this authorization at (888) 319-0777**

- **Specialists:** If additional services are indicated, beyond the requested and approved services, please submit additional Prior Authorizations with appropriate clinical information to support the request for approval.
- **Hospitalizations**: **ALL Admissions require Prior Authorization**. Please, contact the UM department and/or submit a Prior Authorization hospitalization is needed.

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, ensure the Prior Authorization number is noted on the claim.

Do Not Bill the Patient/Member.

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