PRIOR AUTHORIZATION FORM

Van Lang IPA
c/o TECQ Partners
8278 Bellaire Blvd., Ste. B, Houston TX 77036, Telephone No: (888) 319-0777 ext. 699
For faster processing of PA request, use the TECQPartners Portal at: payer.tecqpartners.com
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: ____/____/____ Health Plan □ Amerigroup/Anthem I Service Line □Medicare Advantage

Service Type: ☐ Routine ☐ Urgent ☐ Retro if Retro Date of Service_____/_____/_____

Patient/Member Name: _____ Gender ☐ F ☐ M DOB:____/____/____

Member ID: _____

SECTION B **PROVIDER INFORMATION**

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

☐ Participating Provider ☐ Non-Participating

REQUESTING PHYSICIAN/PROVIDER/FACILITY	REQUESTED PHYSICIAN/PROVIDER/FACILITY
NAME: _____	NAME: _____
SPECIALTY: _____	SPECIALTY: _____
ADDRESS: _____	ADDRESS: _____
PHONE: _____	PHONE:_____
FAX:_____	FAX :_____

If a **Non-Participating Provider is being Requested,** please include: **Provider NPI AND TIN** here:_____

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

Place of Service: ☐ Office ☐Outpatient ☐ Inpatient / if inpt or outpt include Facility Name_____

				Check Unit Type						Check Unit Type			
ICD 10-Code: _____	CPT CODE: _____	Qty		Units		Visits		CPT CODE: _____	Qty		Units		Visits	
ICD 10-Code: _____	CPT CODE: _____	Qty		Units		Visits		CPT CODE: _____	Qty		Units		Visits	
ICD 10-Code: _____	CPT CODE: _____	Qty		Units		Visits		CPT CODE: _____	Qty		Units		Visits	
ICD 10-Code: _____	CPT CODE: _____	Qty		Units		Visits		CPT CODE: _____	Qty		Units		Visits	

Please, include chart notes, to include assessment, test and/or imaging results, treatment to date, response to treatment and plan of care.

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 ext 699**

- **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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