

CSHCN Services Program Authorization Request for Apnea Monitor Rental



Complete the following form and submit to the TMHP-CSHCN Services Program Authorization Department at 12357-B Riata Trace Parkway, Suite 150, MC-A11, Austin TX 78727 or fax to 1-512-514-4222.

For help completing this form, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 or 1-512-514-3000 and select Option 2.

Please print or type requested information below.

Client Information

First name:	Last name:
CSHCN Services Program number: 9-_____ -00	Date of birth:
Address/City/ZIP:	
Diagnosis (ICD-9-CM):	

Statement of Medical Necessity

HCPCS Procedure Code	Service Description
9-A4556 or 9-A4557	<input type="checkbox"/> Purchase electrodes and lead wires for client owned monitor
J-E0618	<input type="checkbox"/> Purchase for ventilator dependent client
L-E0618	<input type="checkbox"/> Rental for ventilator-dependent client for _____ months (includes all accessories and supplies)
L-E0619	<input type="checkbox"/> Initial rental for two months (includes all accessories and supplies)
L-E0619	<input type="checkbox"/> Additional two months' rental (includes all accessories and supplies)

Narrative—Describe client's condition and discuss: (1) Why client needs apnea monitor (if not one of the approved diagnoses); (2) Why client over the age of two months requires apnea monitor; and (3) How long the apnea monitor will be needed.

*If ordering only wires and leads, I certify that the client owns their apnea monitor.
I certify that the client's medical condition is such that all equipment requested above is medically necessary.*

Type or print physician's name:	Telephone:
Physician's signature:	Date signed:

Provider Information

Provider name:	Contact person:
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: CSN
Telephone number:	Fax number:
Address/City/ZIP:	
Provider signature:	Date: