# CSHCN Services Program Authorization Request for Hemophilia Blood Factor Products

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: | |
| Diagnoses (ICD-9-CM): | |

## Product Information:

| |
|---|
| Product name: |
| Product manufacturer: |
| National drug code (NDC): |
| HCPCS code: |
| Product quantity (per I.U.): |

## Prescribing Physician Information:

| | |
|---|---|
| *I certify that the patient's medical condition is such that the treatment requested above is medically necessary.* | |
| Physician name: | Telephone number: |
| Physician signature: | Date: |

## Provider Required Signature and Information:

| | |
|---|---|
| Provider name: | Provider contact name (if any): |
| CSHCN TPI: | NPI: |
| Taxonomy code: | Benefit code: **CSN** |
| Telephone number: | Fax number: |
| Address/City/ZIP: | |
| Provider signature: | Date: |