CSHCN Services Program Prior Authorization Request for Inpatient Psychiatric Care

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.

All sections of this form must be completed. Incomplete prior authorization requests are denied and are reconsidered only when completed and received before the service is provided.

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.

All inpatient psychiatric care stays must be prior authorized. The attending physician and the hospital must be actively enrolled as providers in the CSHCN Services Program. 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:		Telephone number:
Parent or guardian:	Presumptive diagnoses (ICD-9-CM):	
Briefly describe why the client's needs cannot be met in an outpatient setting:		
Date of inpatient stay: _____ through _____ (Not to exceed five days)		
Briefly describe transfer plans:		

Admission Information:

Facility name:	Facility telephone number:
Facility address/City/ZIP:	
Facility CSHCN TPI:	Facility NPI:
Facility taxonomy code:	Benefit code: **CSN**
Contact Person:	