CSHCN Services Program Prior Authorization Request for Medical Foods Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Medical Foods form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Incomplete ***prior authorization*** requests are denied. Requests are considered only when completed and received before the service is provided.
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 or 1-512-514-3000, option 2, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for assistance with this form.
- This form may be submitted by mail to the following address:

  TMHP-CSHCN Services Program Authorization Department
  12357-B Riata Trace Parkway Ste #150 MC-A11
  Austin, TX 78727
- This form may be submitted by fax to 1-512-514-4222.
- Submit only the prior authorization form. Do not submit instruction pages.
- Refer to: Chapter 24, "Medical Nutrition Services."
- This form is not for formula products. For formula products, use the CSHCN Services Program Prior Authorization Request for Additional Nutritional Assessment, Counseling, and Products form.

Client Information

Field Description	Guidelines
First name	Enter the client's first name as indicated on the CSHCN Services Program eligibility form
Last name	Enter the client's last name as indicated on the CSHCN Services Program eligibility form
CSHCN Services Program number	Enter the client's ID number as indicated on the CSHCN Services Program eligibility form
Date of birth	Enter the client's date of birth as indicated on the CSHCN Services Program eligibility form
Address/City/ZIP	Enter the client's address, city, and ZIP
Diagnoses (ICD-9-CM)	Enter the diagnosis code relevant to the need of medical foods

Requested Services

Field Description	Guidelines
Name of product	Indicate the type of requested product
Indicate the reason for the requested product	Place a check mark in the appropriate box and provide a written specification when applicable

Medical Necessity Information

Field Description	Guidelines
Medical necessity information	Document the medical necessity for the requested product

Medical Foods Provider Information

Field Description	Guidelines
Medical foods provider name	Enter the medical foods provider's name
Contact person	Enter the contact name
CSHCN TPI	Enter the medical foods provider's CSHCN Texas provider identifier (TPI)
NPI	Enter the medical foods provider's national provider identifier (NPI)
Taxonomy code	Enter the medical foods provider's taxonomy code
Benefit code	Enter the CSN benefit code
Telephone number	Enter the medical foods provider's telephone number
Fax number	Enter the medical foods provider's fax number
Address/City/ZIP	Enter the medical foods provider's address, city, and ZIP

Physician Information and Required Signature

Field Description	Guidelines
Provider name	Enter the provider's name
CSHCN TPI	Enter the provider's CSHCN TPI
NPI	Enter the provider's NPI
Taxonomy code	Enter the provider's taxonomy code
Benefit code	Enter the CSN benefit code
Telephone number	Enter the provider's telephone number
Fax number	Enter the provider's fax number
Address/City/ZIP	Enter the provider's address, city, and ZIP
Provider signature	Provider must sign in this field
Date	Enter the date the form is signed

Additional Requirements

Prior Authorization request for medical foods:

- Prior authorization is not required if the client has one of the diagnosis codes listed in the CSHCN Services Program Provider Manual Medical Nutrition Services section.
- Prior authorization and documentation of medical necessity is required for all other diagnoses, new products, or products not listed as approved.

CSHCN Services Program Prior Authorization Request for Medical Foods

Client Information:	
First name:	Last name:
CSHCN Services Program number: 9-________________________–00	Date of birth:
Address/City/ZIP:	
Diagnoses (ICD-9-CM):	

Requested Services:	
This form is not for formula products. For formula products use the CSHCN Services Program Prior Authorization Request for Additional Nutritional Assessment, Counseling, and Products form on page B-3.	
Name of product:	
Indicate the reason for the requested product:	
☐ Diagnosis: ______________________________	☐ New product
☐ Other: _________________________________	☐ Product not listed

Medical Necessity Information (attach additional Information if needed)

Medical Foods Provider Information:	
Medical foods provider name:	Contact person:
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Telephone number:	Fax number:
Address/City/ZIP:	

Physician Information and Required Signature:	
Provider name:	
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Telephone number:	Fax number:
Address/City/ZIP:	
Provider signature:	Date:

 Effective Date_06012009/Revised Date_04022009