

Special Medical Prior Authorization (SMPA) Request Form

Use only for requests submitted to the TMHP-SMPA department. Mail completed form to the TMHP Special Medical Prior Authorization at 12357-B Riata Trace Parkway Ste. 150, Austin, TX 78727 or fax to 1-512-514-4213.

Section A: Client information		
Name:		
Medicaid number:	Date of birth: / /	
Section B: Requested procedure or service information		
Type of request: <input type="checkbox"/> Transplant <input type="checkbox"/> Surgery <input type="checkbox"/> Other	Expected dates of service:	
Procedure requested - CPT code	Procedure code description	
Comments:		
Section C: To be completed by requesting physician or prescribing provider- Additional information may be attached		
Diagnoses (ICD-9-CM):		
Statement of medical necessity (Refer to the appropriate section of the Texas Medicaid Provider Procedures Manual for specific prior authorization requirements):		
Physician's name:		
Address/City/ZIP:		
Telephone number:	Fax number:	
TPI:	NPI:	Taxonomy:
Physician's signature:		Date signed:
Section D: Service provider or facility information - If different than provider in Section C		
Provider printed name:		
Contact person:	Date:	
Address/City/ZIP:		
Telephone number:	Fax number:	
TPI:	NPI:	Taxonomy: