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<tr>
<td>B.84</td>
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</tbody>
</table>
B.1 Abortion Certification Statements Form

The signature of the physician must be original script (not stamped or typed). A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes are not acceptable at this time.

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client’s full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed.”

Signature _______________________________________________

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities.”

Signature _______________________________________________

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities.”

Signature _______________________________________________
B.2 Affidavit

THE STATE OF TEXAS

COUNTY OF ________________

AFFIDAVIT

Before me, the undersigned authority, personally appeared, who being by me duly sworn, deposed as follows:

My name is _____________________________________________________________________

I am of sound mind, capable of making the affidavit, and personally acquainted with the facts herein stated:

I am the custodian of the records of ____________________________

(Facility Name and Address)

_____________________________________________________________________________________

Attached here are ______ pages from the medical record of:

(# of Pages)

_____________________________________________________________________________________

(Patient Name)

Hospital Stay period: ____________________________________________________________________

(Admission and Discharge Date)

These pages of records are kept by said Hospital in the regular course of business and it was in the regular course of hospital business for an employee or representative of said Hospital, with knowledge of the act, event, condition, opinion or diagnosis recorded, to make the record or to transmit information thereof to be included in such record and the record was made at or near the time or reasonably soon thereafter.

The record attached hereto is the original or an exact duplicate of the original and no other documents exist on the files for the above named person, which pertain to the admission and discharge, noted above.

_____________________________________________________________________________________

(Signature)

SWORN TO AND SUBSCRIBED before me on this ________ day of ____________________, 200___

_____________________________________________________________________________________

(Notary Public in and for the STATE OF TEXAS)

SEAL

_____________________________________________________________________________________

(Printed Name)

My commission expires: ______________________________
B.3 Ambulance Fax Cover Sheet

Texas Medicaid & Healthcare Partnership  
12365-A Riata Trace Parkway  
Austin, TX 78727-6442

DATE: _____________________________  TIME: _______________(AM) (PM)

FROM: ______________________________  TO: AMBULANCE UNIT

PHONE: _____________________________  PHONE: 1-800-925-9126

FAX: ________________________________  FAX: 1-512-514-4205

*For clients who meet the definition of severely disabled: The client’s physical condition limits his/her mobility, which requires the client to be bed-confined at all times or life support systems to be monitored.

If Hospital to Hospital or Hospital Discharge, supply:

ORIGIN: _____________________________________  DESTINATION: ____________________________

All providers supply the following information:

*The requestor’s name and title _______________________________________________________________

*The client’s full name ______________________________________________________________________

*The client’s Medicaid number ________________________________________________________________

*The initial transport date ___________________________________________________________________

*Full name of the transporting Ambulance Company _____________________________________________

*The Medicaid Provider Number of the transporting Ambulance Company _____ ______________________

*The type of Prior Authorization being requested: _____Annual (12 months) _____Short Term (1–60 days)

Please supply one or more of the following documentation:

*Admit and discharge records for dates of service

*A history and physical that has been done within 6 months

*The Care Plan with Daily Activity Sheet from the Nursing Home within 6 months

*Home Health Care Plan within 6 months

NUMBER OF PAGES INCLUDING COVER SHEET: __________________________
B.4 Authorization to Release Confidential Information (2 Pages)

PATIENT’S NAME ____________________________________________

I authorize ___________________________ and/or ___________________________, and/or
(Name of HMO) (Name of BHO)

the following person/agency/group:

<table>
<thead>
<tr>
<th>Provider/Agency/Group</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>________</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>

To disclose information and records regarding my treatment, medical and/or behavioral health condition to the following professional person/agency, physician and/or facility;

<table>
<thead>
<tr>
<th>Provider/Agency/Group</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>________</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>

Information to be released or exchanged include (check all that apply):

______ History and physical
______ Discharge and Summary
______ Behavioral Health Treatment Records
______ Laboratory Reports
______ Physical Health Treatment Records
______ Medication Records
______ Information on HIV or communicable disease treatment
______ Other (specify) ____________________________________________

The authorized purpose(s) for this release are:

______ Diagnosis and Treatment
______ Coordination of Care
______ Insurance Payment Purposes
______ Other (specify) ____________________________________________
I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. I may revoke this authorization. This authorization is valid until I revoke it or sixty (60) days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

This authorization was explained to me as I signed it of my own free will on:

The ________________ day of ________________, 20__.

__________________________________________  __________________________________________
Signature of Client                                 Signature of Witness

__________________________________________  __________________________________________
Signature of Parent, Guardian, or Authorized Representative, if required

NOTICE OF CLIENT’S REFUSAL TO RELEASE INFORMATION:

I have reviewed the above release of information form and refuse to authorize release of health and behavioral health information to mental health and/or alcohol and/or drug abuse treatment providers and/or physical health providers.

Executed this ________________ day of ________________, 20__.

__________________________________________  __________________________________________
Signature of Client                                 Signature of Witness

__________________________________________  __________________________________________
Signature of Parent, Guardian, or Authorized Representative, if required

THE PERSON SIGNING THIS AUTHORIZATION IS ENTITLED TO A COPY.

TO PERSON RECEIVING THE CONFIDENTIAL INFORMATION:  PROHIBITION OF REDISCLOSURE

Federal and state law protects the confidentiality of the information disclosed to you related to the individual’s alcohol and drug abuse treatment. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Disclosure is limited to the purpose and persons included on the authorization form. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. State laws may also protect the confidentiality of the client’s records.

TO THE INDIVIDUAL FILLING THIS OUT:
You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method of asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact NorthSTAR. You can write to NorthSTAR at 1199 S. Beltline Rd., Coppell, Texas 75019. You can also call the NorthSTAR Helpline at 1-972-906-2500.
### B.5 Authorization to Release Confidential Information (2 Pages) (Spanish)

<table>
<thead>
<tr>
<th>NOMBRE DEL PACIENTE</th>
<th>____________________________</th>
</tr>
</thead>
</table>

Autorizo a __________________________, a ____________________________ y a la siguiente persona, agencia o grupo:

(Nombre de la HMO)   (Nombre de la BHO)

<table>
<thead>
<tr>
<th>Proveedor/Agencia/Grupo</th>
<th>Dirección</th>
<th>Ciudad</th>
<th>Estado</th>
<th>ZIP</th>
</tr>
</thead>
</table>

para que divulgue información y expedientes relacionados con mi tratamiento y estado de salud física, mental o de abuso de sustancias a las siguientes personas, agencias, doctores y centros profesionales:

<table>
<thead>
<tr>
<th>Proveedor/Agencia/Grupo</th>
<th>Dirección</th>
<th>Ciudad</th>
<th>Estado</th>
<th>ZIP</th>
</tr>
</thead>
</table>

La información que se divulgará o intercambiará es, entre otra (marque toda la que sea pertinente):

- [ ] Historia clínica y física
- [ ] Documentos de alta y resumen
- [ ] Documentos del tratamiento de la salud mental y abuso de sustancias
- [ ] Informes de laboratorio
- [ ] Documentos del tratamiento de la salud física
- [ ] Documentos de medicamentos
- [ ] Información del tratamiento del VIH o de las enfermedades transmisibles
- [ ] Otra (especifique) ____________________________

Esta divulgación se ha autorizado con el siguiente propósito (marque todos los que sean pertinentes):

- [ ] Diagnóstico y tratamiento
- [ ] Coordinación de la atención médica
- [ ] Pagos del seguro
- [ ] Otro (especifique) ____________________________
Entiendo que mis expedientes de salud mental y abuso de sustancias están protegidos contra la divulgación bajo la ley federal o estatal. Puedo revocar esta autorización. Esta autorización tiene vigencia hasta que yo la revoque o sesenta (60) días después de que yo haya terminado el tratamiento, lo que suceda primero. Una vez que revoque esta autorización, no se podrá divulgar ninguna información, excepto como lo autorice o lo permita la ley. La copia de archivo se considera equivalente al original.

Se me explicó esta autorización y la firmé por mi propia voluntad:

El día ____________ del mes de ___________________ de 20____.

__________________________________________ ________________________________________
Firma del cliente Firma del testigo

__________________________________________ ________________________________________
Firma del padre, tutor o representante autorizado, si es necesario

AVISO SOBRE LA DECISIÓN DEL CLIENTE DE NO AUTORIZAR LA DIVULGACIÓN DE INFORMACIÓN:

He revisado el formulario anterior para la divulgación de información y me he negado a autorizar la divulgación de información de salud mental y abuso de sustancias a los proveedores de salud física o de tratamiento de salud mental o contra el abuso de alcohol o drogas.

Firmado este día ____________ del mes de ___________________ de 20____.

__________________________________________ ________________________________________
Firma del cliente Firma del testigo

__________________________________________ ________________________________________
Firma del padre, tutor o representante autorizado, si es necesario

La persona que firma esta autorización tiene derecho a una copia.

PARA LA PERSONA QUE RECIBE LA INFORMACIÓN CONFIDENCIAL: PROHIBICIÓN SOBRE LA DIVULGACIÓN
Las leyes federales y estatales protegen la confidencialidad de la información que usted recibió sobre el tratamiento del abuso de alcohol y drogas de la persona. Las normas federales (42 CFR Parte 2) le prohíben a usted dar esta información a otra persona a menos que se haya permitido expresamente en un consentimiento escrito de la persona de quien se trata, o de otra manera permitida por dichas normas. La divulgación se limita al propósito y a la persona anotados en el formulario de autorización. Las reglas federales limitan el uso de la información a investigar o enjuiciar penalmente a algún paciente que tiene problemas de abuso de alcohol o drogas. Es posible que las leyes estatales también protejan la confidencialidad de los expedientes del paciente.

PARA LA PERSONA QUE LLENA ESTE FORMULARIO:
Tiene el derecho de hacernos preguntas sobre este formulario. También tiene el derecho de revisar la información que nos da en el formulario. (Hay algunas excepciones). Si la información está incorrecta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Puede encontrarlo en el Título 1 del Código Administrativo de Texas, Secciones 351.17 a 351.23. Para hablar con alguien acerca de esta forma, o para pedir correcciones, haga el favor de comunicarse con NorthSTAR. Puede comunicarse con NorthSTAR escribiendo a 1199 S. Beltline Rd., Coppell, Texas 75019 ó llamando a la Línea de Ayuda de NorthSTAR al 1-972-906-2500.
B.6 Birthing Center Report (Newborn Child or Children) Form 7484

MAIL FORM TO:
Texas Health and Human Services Commission
Data Integrity 952-X
PO BOX 149030
Austin, TX 78714-9030

PURPOSE: This form is to be used by BIRTHING CENTERS ONLY to report the birth of a child of a mother currently eligible under the Medicaid program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future Medicaid claims payments. If the child’s FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid client number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child’s Medicaid claim.

To avoid delay in processing the child’s Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

<table>
<thead>
<tr>
<th>Mother’s Name (Last, First, MI)</th>
<th>Admission Date (mm/dd/yy)</th>
<th>Mother’s Medicaid client No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s Mailing Address--Street</td>
<td>Mother’s D.O.B. (mm/dd/yy)</td>
<td>Mother’s Medical Record No.</td>
</tr>
<tr>
<td>City, State, ZIP</td>
<td>Child’s Name (Last, First, MI)</td>
<td>Sex</td>
</tr>
<tr>
<td>Child’s Name (Last, First, MI)</td>
<td>Sex</td>
<td>Child’s DOB (mm/dd/yy)</td>
</tr>
<tr>
<td>Child’s Name (Last, First, MI)</td>
<td>Sex</td>
<td>Child’s DOB (mm/dd/yy)</td>
</tr>
</tbody>
</table>

Has the mother relinquished her rights to the newborn child? ................................................................. ❑Yes ❑No

If “Yes,” give date of relinquishment ................................................................. ____________

Certified Midwife

Birthing Center Name

Birthing Center Address – Street

City, State, ZIP

Certification No

C N M 0 0

TPI

Completed By (please type or print)

Birthing Center Telephone No.

Date Form Mailed
**B.7 Child Abuse Reporting Guidelines (2 Pages)**

**HHSC Child Abuse Screening, Documenting, and Reporting Policy for Medicaid Providers**

Each contractor/provider shall comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to investigations of report of child abuse and neglect and the provisions of this HHSC policy. HHSC shall distribute funds only to a contractor/provider who has demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 and this HHSC policy. Contractor/provider staff shall respond to disclosures or suspicions of abuse/neglect of minors by reporting to appropriate agencies as required by law.

**PROCEDURES**

I. Each contractor/provider shall adopt this policy as its own.

II. Each contractor/provider shall report suspected sexual abuse of a child as described in this policy and as required by law.

III. Each contractor/provider shall develop an internal policy and procedures that describe how it will determine, document, and report instances of abuse, sexual or nonsexual, in accordance with the Texas Family Code, Chapter 261.

**REPORTING GENERALLY**

I. Professionals as defined in the law are required to report not later than the 48th hour after the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

II. Nonprofessionals shall immediately make a report after the nonprofessional has cause to believe that the child’s physical or mental health or welfare has been adversely affected by abuse.

III. A report shall be made regardless of whether the contractor/provider staff suspect that a report may have previously been made.

IV. Reports of abuse or indecency with a child shall be made to:

   A. Texas Department of Family and Protective Services (DFPS) if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (DFPS Texas Abuse Hotline at 1-800-252-5400, operated 24 hours a day, seven days a week);

   B. Any local or state law enforcement agency;

   C. The state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred; or

   D. The agency designated by the court to be responsible for the protection of children.

V. The law requires that the following be reported:

   A. Name and address of the minor, if known;

   B. Name and address of the minor’s parent or the person responsible for the care, custody, or welfare of the child if not the parent, if known; and

   C. Any other pertinent information concerning the alleged or suspected abuse, if known.

VI. Reports can be made anonymously.

VII. A contractor/provider may not reveal whether or not the child has been tested or diagnosed with HIV or AIDS.

VIII. If the identity of the minor is unknown (e.g., the minor is at the provider’s office to anonymously receive testing for HIV or an STD), no report is required.
REPORTING SUSPECTED SEXUAL ABUSE

I Each contractor/provider shall ensure that its employees, volunteers, or other staff report a victim of abuse who is an unmarried minor under 14 years of age and is pregnant or has a confirmed sexually transmitted disease acquired in a manner other than through perinatal transmission.

II The Texas Family Code, Chapter 261, requires other reporting of other instances of sexual abuse. Other types of reportable abuse may include, but are not limited to, the actions described in:
   A Penal Code, §21.11(a) relating to indecency with a child;
   B Penal Code, §21.01(2) defining “sexual contact”;
   C Penal Code, §43.01(1) or (3)-(5) defining various sexual activities; or
   D Penal Code, §22.011(a)(2) relating to sexual assault of a child;
   E Penal Code, §22.021(a)(2) relating to aggravated sexual assault of a child.

III Each contractor/provider may utilize the attached Checklist for HHSC Monitoring for all clients under 14 years of age. The checklist, if used, shall be retained by each contractor/provider and made available during any monitoring conducted by HHSC.

TRAINING

I Each contractor/provider shall develop training for all staff on the policies and procedures in regard to reporting child abuse. New staff shall receive this training as part of their initial training/orientation. Training shall be documented.

II As part of the training, staff shall be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.
B.8 Child Abuse Reporting Guidelines, Checklist for HHSC Monitoring

Date: ________________________________

Client’s name: ________________________________________________________________________

Client’s age (use this checklist only if the client is under 14): ________________________________

Staff person conducting screening: _________________________________________________________

Each contractor/provider shall ensure that its employees, volunteers, or other staff report a victim of child abuse who is a minor under 14 years of age who has engaged in sexual activity with any individual to whom the minor is not married. Sexual activity would be indicated if the minor is pregnant or has confirmed diagnosis of a sexually transmitted disease acquired in a manner other than through perinatal transmission.

Using the criteria above, did you determine that a report of child abuse is required? ______ Yes ______ No

If "yes," please report and complete the information below.

Report was made: _____ Yes _____ No

Staff person who submitted the report (optional): ____________________________________________

Date reported: __________________________________________________________________________

Name of agency to which report was made: _________________________________________________

DFPS call ID# or law enforcement assigned # (optional): _____________________________________

Name of person who received report (optional): _____________________________________________

Phone number of contact (when applicable): ________________________________________________

Use of the checklist for HHSC monitoring of reporting of abuse of children younger than 14 years of age who are pregnant or have STDs does not relieve contractors or subcontractors of the requirements in Chapter 261, Texas Family Code, to report any other instance of suspected child abuse.
B.9 Claim Status Inquiry (CSI) Authorization Form

This form is for ACUTE CARE providers only.

If you are a Long Term Care provider, contact TMHP’s EDI Help Desk at 888-863-3638 to request the correct form.

The following information MUST be completed before you can be granted Claim Status Inquiry (CSI) access.

1. Enter your Production User ID: ________________________________

2. Enter your Production User ID Password: __________________________

   The TMHP Production User ID (Submitter ID) is the electronic mailbox ID used for downloading your Claim Status Inquiry reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.

3. Select Action:
   A ☐ Add Claim Status Inquiry Privileges
   B ☐ Revoke Claim Status Inquiry Privileges

4. Enter organization information:
   List the billing Texas Provider Identifier (TPI) number(s) you choose to access using the Production User ID given above. Submit additional copies of this form if you need to add more TPI numbers.

   Provider Name
   Must be the name associated with the TPI Base number listed at right.

   7–Digit BILLING TPI Base Number
   The first 7 digits of the 9 digit TPI number.*

   ____________________________________________  ______________________________
   ____________________________________________  ______________________________
   ____________________________________________  ______________________________
   ____________________________________________  ______________________________
   ____________________________________________  ______________________________
   ____________________________________________  ______________________________
   ____________________________________________  ______________________________
   ____________________________________________  ______________________________
   ____________________________________________  ______________________________
   ____________________________________________  ______________________________

   *Note: Performing TPI numbers do not have Claim Status Inquiry access. Enter only BILLING TPI numbers.

5. Enter Requestor Information:

   Name: ________________________________

   Title: ________________________________

   Signature: ________________________________

   Telephone Number: ________________________________ ext.

   Fax Number: ________________________________ ext.

6. Return this form to:

   Texas Medicaid & Healthcare Partnership
   Attention: EDI Help Desk, MC–B14
   PO Box 204270
   Austin, TX  78720-4270

   Or Fax to
   512-514-4228 or 512-514-4230

   DO NOT WRITE IN THIS AREA — For Office Use

   Input By: ________________________________ Input Date: ________________________________ Mailbox ID: ________________________________
# B.10 Client Medicaid Identification (Form H3087) (18 Pages)

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

<table>
<thead>
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<th>BiN</th>
<th>BP</th>
<th>TP</th>
<th>Cat.</th>
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<td>123456789</td>
<td>AUGUST 31, 2006</td>
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</table>

952-X 123456789 40 30 02 030711
JOHN DOE
743 GOLF IRONS
DELL VALLE TX 78617

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✔ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY DATE</th>
<th>MEDICARE NO.</th>
<th>EYE EXAM</th>
<th>EYE GLASSES</th>
<th>HEARING AIDS</th>
<th>DENTAL</th>
<th>PRESCRIPTIONS</th>
<th>MEDICAL SERVICES</th>
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If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-G1/January 2006
WHAT IF YOU GET A BILL? If you get a bill from a doctor, hospital, Medicaid to pay for your services. This is your MEDICAID IDENTIFICATION form. When you get any

WHAT IF THE SERVICES REQUESTED FOR YOU ARE DENIED? You will receive a letter telling you the request was denied and that you have the right to ask for a fair hearing. You may ask for a hearing in writing or by calling. The address and telephone number will be listed on the letter that you get.

CAUTION: If you accept Medicaid benefits (services or supplies), the state of Texas has the right to receive payment for those services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

FOR QUESTIONS REGARDING MEDICAID ELIGIBILITY, ID FORMS, AND ADDRESS CHANGES: Please contact the Texas Health and Human Services Commission (HHSC) office in your area. The telephone numbers and addresses are listed in your local telephone book.

For Questions About Other Medicaid Programs, You May Call the Following Toll-Free Numbers:

1-800-252-8263 BENEFITS/POLICY – To find out what Medicaid pays for, or to find a provider.
1-800-335-8957 MEDICAID BILLING PROBLEMS – Any medical bills you may receive.
1-877-847-8377 TEXAS HEALTH STEPS – Care for clients up to age 21 including medical and dental check-ups.
1-877-633-8747 MEDICAL TRANSPORTATION – For help with rides when you have no other way to get to and from the doctor, dentist, or drug store at no cost to you.
1-866-566-8989 STARLINK – Problems with the Managed Care STAR Program.
1-800-335-8957 MEDICALLY NEEDY PROGRAM (MNP) – About your spend down case.
1-800-458-9858 LONG TERM CARE (LTC) – Nursing Home Care.
1-800-846-7307 THIRD PARTY RESOURCES (TPR) – If you have other insurance.
1-800-436-6184 FRAUD – Medicaid, Food Stamps and TANF.
1-800-440-0493 HEALTH INSURANCE PREMIUM PAYMENT SYSTEM (HIPP) – For help with private health insurance premiums.
1-800-772-1213 SOCIAL SECURITY ADMINISTRATION (SSA) – To report an address change if you are an SSI client.

WHAT IF THE SERVICES REQUESTED FOR YOU ARE DENIED? You will receive a letter telling you the request was denied and that you have the right to ask for a fair hearing. You may ask for a hearing in writing or by calling. The address and telephone number will be listed on the letter that you get.

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P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Appendix B

Form H3087-G2
January 2006

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run: 07/05/2006
BIN: 610098
SP: 40
TP: 02
Cat. No.: 123456789
GOOD THROUGH: JULY 31, 2006

952-X 123456789
40 02 030731
JANE DOE
743 GOLF IRONS
HUNTINGTON TX 75949

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES
CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✔ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!
¡LEA EL DORSO DE LA FORMA!

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-G2/January 2006
Anyone listed below can get Medicaid services

Anyone listed below can get Medicaid services

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✔ on the line to the right of your name means that you can get that service too.

For additional information regarding limitation to one primary care provider and/or pharmacy, call the Limited Program at 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

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Appendix B

MEDICAID IDENTIFICATION

IDENTIFICACIÓN DE MEDICAID

Date Run: 07/24/2006
B.20  15 ATFF 01-00015

Texas Health and Human Services Commission

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Good Through: JULY 31, 2006

Texas Health and Human Services Commission

Form H3087-GM

January 2006

MEDICAID IDENTIFICATION

GOOD THROUGH: JULY 31, 2006

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

READ THE BACK OF THIS FORM!
¡LEA EL DORSO DE LA FORMA!

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY DATE</th>
<th>TPR</th>
<th>MEDICARE NO.</th>
<th>EYE EXAM</th>
<th>PRESCRIPTIONS</th>
<th>MEDICAL SERVICES</th>
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</table>

NOTICE TO PROVIDER

This recipient is eligible for regular Medicaid benefits.

This recipient is also eligible for coverage of Medicare deductible and coinsurance liabilities on valid Medicare claims. Coverage is subject to Medicaid reimbursement limitations.

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-GM: January 2006
**Texas Health and Human Services Commission**

**MEDICAID IDENTIFICATION**

**IDENTIFICACIÓN PARA MEDICAID**

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<td>M</td>
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**QUALIFIED MEDICARE BENEFICIARIES**

NO MEDICARE PRESCRIPTION DRUGS AUTHORIZED. YOU ARE ELIGIBLE FOR MEDICARE RX.

NO SE AUTORIZÓ NINGUNA RECETA MÉDICA DE MEDICARE. USTED LLENA LOS REQUISITOS PARA RECIBIR MEDICARE RX.

Notice to Providers:

THIS CLIENT IS ELIGIBLE FOR QMB BENEFITS ONLY.

This client is eligible only for coverage of Medicare deductible and coinsurance liabilities on valid Medicare claims. Coverage is subject to Medicaid reimbursement limitations.
| ID NO.  | NAME       | DATE OF BIRTH | SEX  | ELIGIBILITY DATE | TPR  | MEDICARE NO. | EYE EXAM | EYE GLASSES | HEARING AID | ICF-MR DENTAL | PRESCRIPTIONS | MEDICAL SERVICES |
|--------|------------|---------------|------|------------------|------|--------------|----------|-------------|-------------|--------------|---------------|----------------|----------------|
| 765432198 | JANE DOE  | 05-19-1981 | F    | 11-14-2002       |      |              |          |             |             |              |               |                |

Form 3087EM/8-2000
P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Date Run 07/24/2006 BIN 610098 BP 13 TP 13 Cat. 04 Case No. 123456789

GOOD THROUGH: AUGUST 31, 2006

HOSPICE

952-X 123456789 13 13 04 030831
JANE Doe
743 GOLF IRONS
CARROLTON TX 75006

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES
Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

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<th>SEX</th>
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<td>F</td>
<td>07-01-1997</td>
<td>✓ ✓ ✓ ✓</td>
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If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-GH: January 2006
Appendix B

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Date Run 07/15/2006  BIN 610098  SP 13  TP 13  Cat. 04  Case No. 123456789

GOOD THROUGH:  JULY 31, 2006

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

ID NO. NAME DATE OF BIRTH SEX ELIGIBILITY DATE TPR MEDICARE NO.

765432198 JANE DOE 01-05-1983 F 10-01-1995

/ /WELBY MARCUS L MD

191 ATFF 01-00191

LIMITED PHARMACY

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PHARMACY
Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA
Llame al Programa Limitado a 1-800-436-6184

** TO PHARMACY: ** HAPPY PHARMACY
** 11223 WEST 27th ** AUSTIN TX 78759

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-P1/January 2006
Notice to Providers: This client has been approved for Presumptive Medicaid Eligibility for Pregnant Women until the regular Medicaid determination is made.

Medicaid covered services during the presumptive eligibility period are limited to medically necessary outpatient services and family planning services. Labor, delivery, inpatient services and THSteps medical and dental services are not covered.

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.
ANYONE LISTED BELOW CAN GET MEDICAID SERVICES
You are enrolled in STAR+PLUS, the state’s new plan for Medicaid in Harris County. You have a Primary Care Provider (PCP). Your health plan and PCP are listed under your name. If you have Medicare you will not have a PCP listed.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.
READ BACK OF THIS FORM!

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY DATE</th>
<th>TPR</th>
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BEST HEALTH PLAN /1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PRIMARY CARE PHARMACY Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA Llame al Programa Limitado a 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-PL/January 2006
**Texas Health and Human Services Commission**

**MEDICAID IDENTIFICATION**

**IDENTIFICACIÓN DE MEDICAID**

RETURN SERVICE REQUESTED  
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Date Run: 07/15/2006  
BIN: 610098  
BP: 13  
TP: 13  
Cat.: 04  
Case No.: 123456789  
GOOD THROUGH: JULY 31, 2006

---

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan’s name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP’s name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program? Please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

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<th>ID NO.</th>
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</table>

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

---

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años o más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el Programa STAR? Por favor, llame al 1-800-964-2777 para conseguir ayuda. ¡LEA EL DORSO DE LA FORMA!

---

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

---

Form H3087-S1/January 2006
Anyone listed below can get Medicaid services

You are enrolled in the STAR Program. Your health plan’s name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP’s name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

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\[\] / WELBY MARCUS L MD

Limited pharmacy

For additional information regarding limitation to one pharmacy
Call the Limited Program at 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run BIN TP Cat. Case No. GOOD THROUGH: VALIDA HASTA: JULY 31, 2006
07/15/2006 610098 01 02 123456789

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77056

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES
You are enrolled in STAR+PLUS, the state’s plan for Medicaid in Harris County. Your health plan’s name and telephone number are listed under your name. Call your health plan for your Primary Care Provider (PCP) name or refer to your health plan identification card. If you have Medicare you will not have a STAR+PLUS PCP.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

P.O. BOX 149030 952-X
AUSTIN, TEXAS  78714-9030
RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.
**Primary Care Case Management (PCCM)**

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You now receive your Medicaid medical care through Primary Care Case Management (PCCM). Your primary care provider (PCP) is listed below. If you want to pick a different PCP, call toll-free 1-888-302-6688.

Your PCP is your first stop for getting medical care. When you are sick or injured, your PCP will help you. Your PCP can also assist with THSteps checkups for children and teenagers, prenatal and well woman care. For more information, read your handbook, Primary Care Provider and Hospital List, or call PCCM toll-free at 1-888-302-6688.

**READ BACK OF THIS FORM!**

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY DATE</th>
<th>TPR</th>
<th>MEDICARE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>765432198</td>
<td>JANE DOE</td>
<td>02-04-1983</td>
<td>F</td>
<td>07-01-2005</td>
<td></td>
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</tbody>
</table>

/ /WELBY MARCUS L MD

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-S4/January 2006
Form H3087-SL/January 2006

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run BIN EP TP Cat. Case No. GOOD THROUGH: VALIDA HASTA:
07/15/2006 610098 01 02 123456789 JULY 31, 2006

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77093

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES
CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID
You are enrolled in the STAR Program. Your health plan’s name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP’s name.
Si está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Questions about the STAR Program?
Please call 1-800-964-2777 for help.
READ BACK OF THIS FORM!
¿Tiene preguntas sobre el Programa STAR?
Por favor, llame al 1-800-964-2777 para conseguir ayuda.
¡LEA EL DORSO DE LA FORMA!

BEST HEALTH PLAN /1-800-123-4567/ CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION
PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA
Llame al Programa Limitado a 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.
Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.
ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state’s plan for Medicaid in Harris County. Your health plan’s name and telephone number are listed under your name. Call your health plan for your Primary Care Provider (PCP) name or refer to your health plan identification card. If you have Medicare you will not have a STAR+PLUS PCP.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

NOTE: Prescription benefits for Medicare clients age 21 and over may be limited to three (3) per month.

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77231

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.
Texas Health and Human Services Commission

MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run: 07/15/2006
BIN: 610098
TP: 01
Cat.: 02
Case No.: 123456789

GOOD THROUGH: JULY 31, 2006

Forms

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77096

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES
You are enrolled in the STAR Program. Your health plan’s name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP’s name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?
Please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY DATE</th>
<th>TPR</th>
<th>MEDICARE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>765432198</td>
<td>JANE DOE</td>
<td>07-25-1979</td>
<td>F</td>
<td>01-01-2005</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BEST HEALTH PLAN /1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-ST/January 2006
# B.11 Credit Balance Refund Worksheet

Provider Name: ___________________________________________________

TPI: ____________________________________________________________

<table>
<thead>
<tr>
<th>ICN/PCN</th>
<th>Patient Name</th>
<th>Insurance Company Name/Address</th>
<th>Policy Number</th>
<th>Group Number</th>
<th>Insurance Paid Amount</th>
<th>Refund Amount</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

Mail refund checks, made payable to TMHP, along with the "Credit Balance Refund Worksheet" to the following address:

Texas Medicaid & Healthcare Partnership  
CBA Worksheets & Refunds  
PO Box 202948  
Austin TX 78720-9981
B.12 DME Certification and Receipt Form

This certification is required by section 32.024 of the Human Resources Code and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client. This is to certify that on (month, day, year)............................................:

- The client received the ..........................................(name of item/equipment) as prescribed by the physician.
- The equipment has been properly fitted to the client and/or meets the client’s needs.
- The client, the parent or guardian of the client, and/or the primary caregiver of the client, has received training and instruction regarding the equipment’s proper use and maintenance.

..................................................................................................................................................................
Signature of DME Supplier                                      Signature of Client/Parent/Guardian/
                                                               Primary Caregiver

Certificación y recibo de equipo médico duradero (DME)

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de poder reembolsar al proveedor del equipo médico duradero por cualquier equipo médico proporcionado al cliente de Medicaid. Esto certifica que el: (mes, día, año)..............................................................................................

- El cliente recibió [el] [la] [los] [las] .............................................(nombre del artículo o equipo) que el doctor recetó.
- El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.
- El cliente, su padre o tutor, o el cuidador principal del cliente, ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

..................................................................................................................................................................
Firma del Proveedor del Equipo Médico Duradero                Firma del Cliente, Padre, Tutor o Cuidador principal
Appendix B

### B.13 Donor Human Milk Request Form

#### Donor Human Milk Request Form

(Must be Reordered Every 180 Days)

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Client Medicaid Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth:</td>
<td>Client’s weight:</td>
</tr>
</tbody>
</table>

**Parts A and B must be completed and copies retained in both the physician’s and the milk bank’s records. These forms and clinical records are subject to retrospective review.**

#### Part A

The physician must keep up-to-date documentation of medical necessity and the signed written consent form in the child’s clinical record to be considered for Medicaid reimbursement.

- The medical necessity for breast milk* is:
  - Child’s diagnosis:
  - Date of last feeding trial:

  Reason donor milk is the only appropriate source of human milk for this client:

  (* This information must be substantiated by written documentation in the clinical record of why the particular infant cannot survive and gain weight on any appropriate formula, such as an elemental formula or enteral nutritional product, other than donor human breast milk, and that a clinical feeding trial has occurred every 180 days.)

- The parent/guardian has signed and dated an informed consent that the risks and benefits of using banked donor human milk have been discussed with them.

**Dates of service requested:**

| From | To | Quantity Requested:

<table>
<thead>
<tr>
<th>Physician’s Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Name</td>
<td>Physician License Number</td>
</tr>
<tr>
<td>Physician’s Fax Number</td>
<td>Physician’s TPI</td>
</tr>
</tbody>
</table>

#### Part B

The particular donor human milk bank adheres to quality guidelines consistent with the Human Milk Banking Association of North America, or other standards established by HHSC. Yes ✓ No ❏

**Dates of service provided:**

| From | To | Quantity Provided:

<table>
<thead>
<tr>
<th>Milk Bank Name</th>
<th>Milk Bank TPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk Bank Representative Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Milk Bank Representative’s Name</td>
<td>Milk Bank Fax Number</td>
</tr>
</tbody>
</table>
**B.14 Electronic Funds Transfer (EFT) Information**

Electronic Funds Transfer (EFT) is a payment method to deposit funds for claims approved for payment directly into a provider’s bank account. These funds can be credited to either checking or savings accounts, provided the bank selected accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, ensuring funds are directly deposited into a specified account.

The following items are specific to EFT:

- Applications are processed within five workdays of receipt.
- Pre-notification to your bank takes place on the cycle following the application processing.
- Future deposits are received electronically after pre-notification.
- The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider’s account during the weekly cycle.
- Specific deposits and associated R&S reports are cross-referenced by both Texas Provider Identifier (TPI) and R&S number.
- EFT funds are released by TMHP to depository financial institutions each Friday.
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

- Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Please contact your financial institution regarding posting time if funds are not available on the release date.
- However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer’s withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn should work out the best way to serve their customer’s needs.
- In all cases, credits received should be posted to the customer’s account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. You must return a voided check or deposit slip with the agreement to the TMHP address indicated on the form.

Contact TMHP Customer Service at 1–800–925–9126 if you need assistance.
# B.15 Electronic Funds Transfer (EFT) Authorization Agreement

*Enter ONE Texas Provider Identifier (TPI) per Form*

**NOTE:** Complete all sections below and attach a voided check or a photocopy of your deposit slip.

### Type of Authorization:
- [ ] NEW
- [ ] CHANGE

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>Nine–Character Billing TPI</td>
</tr>
<tr>
<td>Provider Accounting Address</td>
<td>Provider Phone Number</td>
</tr>
<tr>
<td></td>
<td>(                  )</td>
</tr>
<tr>
<td></td>
<td>ext.</td>
</tr>
<tr>
<td>Bank Name</td>
<td>ABA/Transit Number</td>
</tr>
<tr>
<td>Bank Phone Number</td>
<td>Account Number</td>
</tr>
<tr>
<td>Bank Address</td>
<td>Type Account (check one)</td>
</tr>
<tr>
<td></td>
<td>□ Checking</td>
</tr>
<tr>
<td></td>
<td>□ Savings</td>
</tr>
</tbody>
</table>

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its health insuring contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

---

**Authorized Signature**

**Date**

**Title**

**Email Address (if applicable)**

**Contact Name**

**Phone**

---

**Return this form to:**
Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin TX 78720–0795

**DO NOT WRITE IN THIS AREA — For Office Use**

<table>
<thead>
<tr>
<th>Input By:</th>
<th>Input Date:</th>
</tr>
</thead>
</table>
B.16 External Insulin Pump

1. Lab values, current and past blood glucose levels, including glycosylated hemoglobin (Hb/A1C) levels. Note date of lab draws.

2. History of severe glycemic excursions, brittle diabetes, hypoglycemic/hyperglycemic reactions, nocturnal hypoglycemia, any extreme insulin sensitivity, and/or very low insulin requirements.

3. Any wide fluctuations in blood glucose level before mealtimes.

4. Any dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL.

5. Day-to-day variations in work schedule, mealtimes and/or activity level, which require multiple insulin injections.

6. Completed and signed Home Health (Title XIX) DME/Medical Supplies Physician Order Form.

7. For purchase after initial trial period: statement of client’s compliance and effectiveness of the pump.

_____________________________________________________ ________________________
Physician Signature Date

_____________________________________________________
Print Physician’s Name
Appendix B

B.17 Federally Qualified Health Center Report (Newborn Child or Children)
Form 7484

PURPOSE: This form is to be used by FEDERALLY QUALIFIED HEALTH CENTERS ONLY to report the birth of a child of a mother currently eligible under the Medicaid program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future medicaid claims payments. If the child’s FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid client number of the newborn child, please complete this document and submit it to the HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child’s Medicaid claim.

To avoid delay in processing the child’s Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Has the mother relinquished her rights to the newborn child? □ Yes □ No

If “Yes,” give date of relinquishment ________________________________

Mother’s Name (Last, First, Mi)

Admission Date (mm/dd/yy)

Mother’s Medicaid Recipient No.

Mother’s Mailing Address—Street

Mother’s D.O.B. (mm/dd/yy)

Mother’s Medical Record No.

City, State, ZIP

Sex □ M □ F

Child’s Name (Last, First, Mi)

Child’s D.O.B. (mm/dd/yy)

Child’s Medical Record No.

Child’s Name (Last, First, Mi)

Sex □ M □ F

Child’s D.O.B. (mm/dd/yy)

Child’s Medical Record No.

Child’s Name (Last, First, Mi)

Sex □ M □ F

Child’s D.O.B. (mm/dd/yy)

Child’s Medical Record No.

Has the mother relinquished her rights to the newborn child? □ Yes □ No

Child’s Attending Physician

Physician’s Medical Lic. No.

TPI

Certified Midwife

Certification No

TPI

Health Center Name

Completed By (please type or print)

FQHC Telephone No.

Date Form Mailed

Data Rec’d in Data Integrity

Texas Health and Human Services Commission

Data Integrity 952-X

PO Box 149030

Austin, TX 78714-9030
# B.18 Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)

<table>
<thead>
<tr>
<th>Name (Last, First, Middle Initial)</th>
<th>Client No.</th>
<th>Age</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street, City, State, ZIP Code)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Examination</td>
<td>Place of Examination</td>
<td>Pure-tone Audiometry: ANSI 1969 <strong>Yes</strong> <strong>No</strong></td>
<td></td>
</tr>
</tbody>
</table>

**INDICATE WITH AN ASTERISK (*) BY RECORDED THRESHOLD WHEN MASKING IS USED**

**AIR CONDUCTION SOUND FIELD TEST RESULT IN DECIBELS**
(Completed by physicians and audiologist only)

<table>
<thead>
<tr>
<th>500 Hz</th>
<th>1000 Hz</th>
<th>2000 Hz</th>
<th>4000 Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>LE</td>
<td></td>
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<td></td>
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<tr>
<td>RE</td>
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<td>Masking Level LE</td>
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<td>Masking Level RE</td>
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</table>

**BONE CONDUCTION**

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<th>1000 Hz</th>
<th>2000 Hz</th>
<th>4000 Hz</th>
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<tr>
<td>Masking Level RE</td>
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**SPEECH AUDIOMETRY**

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<th>SRT</th>
<th>PB Quiet</th>
<th>PB Level</th>
<th>Thres. Disc.</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>RE</td>
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<td>Masking Level LE</td>
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<tr>
<td>Masking Level RE</td>
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**COMMENTS**

Is report of Physician’s Examination attached? **Yes** **No**

FITTER AND DISPENSER: The fitter and dispenser must sign below.

Name of Fitter and Dispenser (please type or print)

Signature - Fitter and Dispenser ___________________________ Date __________

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

I, ___________________________ (Signature of Physician or Audiologist) ___________________________ (Title of Person Certifying) do hereby certify that I am ___________________________ and that I am duly authorized to make this certification for and on behalf of ___________________________ (Name of Payee Company Claimant) ___________________________.

I further certify that the attached invoice is correct and that it corresponds in every particular with the supplies and/or services contracted for. I further certify that the account is true, correct and unpaid.

(Signature of Physician or Audiologist) ___________________________ Date __________
## B.19 HHSC Physician Attestation Statement

<table>
<thead>
<tr>
<th>Provider Name</th>
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<tbody>
<tr>
<td>Texas Provider Identifier (TPI):</td>
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<tr>
<td>Client Name:</td>
<td></td>
</tr>
<tr>
<td>DOB:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Date of Admission:</td>
<td>Date of Discharge:</td>
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<tr>
<td>Discharge Status:</td>
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<tr>
<td>Secondary Diagnoses:</td>
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<tr>
<td>Principal Procedure:</td>
<td></td>
</tr>
<tr>
<td>Other (Secondary) Procedures:</td>
<td></td>
</tr>
</tbody>
</table>

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

<table>
<thead>
<tr>
<th>Attending Physician Signature</th>
<th>Date of Signature</th>
</tr>
</thead>
</table>

Texas Medicaid Program  
March 29, 2001
B.20 HHSC Physician Attestation Statement Requirements

The following information must be included on the attestation statement for a hospital’s request for an oral appeal to be considered:

- Provider name and Texas Provider Identifier (TPI)
- Client’s name, date of birth, sex, and Medicaid number
- Date of admission and discharge
- Discharge status
- Principal diagnosis\(^1\), secondary diagnoses\(^2\), and the principal procedures (with proper sequencing and diagnostic and procedure codes)\(^3\)
- Statement: “I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.”
- Attending physician’s dated signature (immediately below the statement). In lieu of the attending physician, the statement may be signed by another physician involved in the patient’s care.

Note: The attending physician’s signature, along with the other information required above, may be provided by electronic means through a hospital data system provided that HHSC is given sufficient evidence that this system meets appropriate legal requirements.

---

1. The *principal diagnosis* is the diagnosis (condition) established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
2. The secondary diagnoses are conditions that affect the patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care, or monitoring, or, in the case of a newborn, clinically significant implications for future health care needs as deemed by a physician.
3. Normal newborn conditions or routine procedures are not considered.
B.21 Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)

General Instructions

This form must be completed and signed as outlined in the instructions below before DME/medical supplies providers contact TMHP Home Health Services for prior authorization.

Either the DME supplier/Medicaid provider or the prescribing physician may initiate the form. This completed form must be retained in the records of both the DME supplier/medical provider and the prescribing physician, and is subject to retrospective review. This form becomes a prescription when the physician has signed section B. This form cannot be accepted beyond 90 days from the date of the prescribing physician’s signature.

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer’s suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

All fields must be filled out completely. The prescribing physician’s TPI is only required if the Physician is a Texas Medicaid provider.

Section A: Requested Durable Medical Equipment and Supplies

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer’s suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

<table>
<thead>
<tr>
<th>Item No.</th>
<th>HCPCS Code</th>
<th>Quantity</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>J-E1399</td>
<td>1</td>
<td>$50.00</td>
</tr>
<tr>
<td>2</td>
<td>J-E1220</td>
<td>1</td>
<td>$2500.00</td>
</tr>
</tbody>
</table>

Examples of Supplies

<table>
<thead>
<tr>
<th>Item No.</th>
<th>HCPCS Code</th>
<th>Quantity</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9-A4253</td>
<td>2 boxes</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>9-A4259</td>
<td>1 box</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>9-A4245</td>
<td>1 box</td>
<td>N/A</td>
</tr>
</tbody>
</table>

5
Section B: Diagnosis and Medical Information

Section B is a prescription for DME/supplies and must be filled out by the prescribing physician. The prescribing physician must indicate the ICD-9-CM code with a brief description, corresponding to the item number requested from Section A and complete justification for determination of medical necessity for the requested item(s). If applicable, include height/weight, wound stage/dimensions and functional/mobility. **The date last seen must be within the past 12 months.**

The prescribing physician must indicate the duration of need for the prescribed supplies/DME. The estimated duration of need should specify the amount of time the supplies/DME will be needed, such as six weeks, three months, lifetime, etc. The prescribing physician's TPI (if a Medicaid provider) and license number must be indicated. **Signatures from Nurse Practitioner’s, Physician Assistants, and Chiropractors will not be accepted. Signature stamps and date stamps are not acceptable.**

### Diagnosis and Medical Need Information

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Requested Section A No.</th>
<th>Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies¹,²</th>
</tr>
</thead>
<tbody>
<tr>
<td>438.</td>
<td>1, 2</td>
<td>Unable to get in and out of the tub or shower</td>
</tr>
<tr>
<td>278.01</td>
<td>2</td>
<td>Need swing-away arms and legs for transfer secondary to hemiparesis and need oversize chair weighing 400 lbs</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
². Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

### Examples of Supplies

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Requested Section A No.</th>
<th>Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies¹,²</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.01</td>
<td>3, 4, 5</td>
<td>Test TID</td>
</tr>
</tbody>
</table>

¹. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
². Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

Physicians must indicate their professional license number. If the prescribing physician is out of state, the physician must provide the license number and state of professional licensure. Texas Medicaid P0 TPIs, ZO group TPIs, and UPIN numbers are not acceptable as licensure.

The **Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form** must be used when prescribing more than 5 items. The **Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form** must accompany the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form. **Addendums received without this form will not be accepted.**

**Reminder:** Home health services are not a benefit for clients residing in a nursing facility, hospital, or intermediate care facility.

**Note for DME:** The DME company must also complete the DME Certification & Receipt Form. All equipment is to be assembled, installed, and used pursuant to the manufacturer’s instructions and warning.
# Appendix B

## B.22 Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician's signature. Fax COMPLETED form to 1-512-514-4209

### Section A --- Requested Durable Medical Equipment and Supplies

<table>
<thead>
<tr>
<th>Item #</th>
<th>HCPCS Code</th>
<th>Description of DME/Medical Supplies</th>
<th>Quantity</th>
<th>Price</th>
<th>Prior Auth Required?</th>
<th>Beyond Quantity Limit?</th>
<th>Custom Item?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Y □ N</td>
<td>□ Y □ N</td>
<td>□ Y □ N</td>
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<tr>
<td>2</td>
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<td>□ Y □ N</td>
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<td>3</td>
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<td>5</td>
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<td></td>
<td>□ Y □ N</td>
<td>□ Y □ N</td>
<td>□ Y □ N</td>
</tr>
</tbody>
</table>

1. If "Yes", additional documentation must be provided to support determination of medical necessity.

### Section B --- Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Brief Diagnosis Descriptor</th>
<th>Requested Item Number from Section “A” ²</th>
<th>Complete justification for determination of medical necessity for requested item(s). ² (Refer to Section “A” footnote 1)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

2. Each item requested in section “A” must have a correlating diagnosis and medical necessity justification.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status in table below.

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Wound stage/dimensions</th>
<th>Functional/mobility status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

NOTE: The "DATE LAST SEEN" and "DURATION of NEED" must be filled in!

- Date last seen by physician: _____/____/____
- Duration of need for DME: ____________ month(s)  
- Duration of need for supplies: ____________ month(s)  

By signing this form, I hereby attest that the information completed in Section “A” is consistent with the determination of the client’s current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client’s home when used as prescribed.

Signature and attestation of prescribing physician: __________________________________________ Date: _____/____/____  

Signature stamps and date stamps are not acceptable

- Prescribing Physician’s TPI number: ______________________  
- Prescribing Physician’s LICENSE number: ______________________

- Check if all of the information in Section “A” was complete at the time of prescribing provider signature.
**B.23 Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form**

### Section A --- Requested Durable Medical Equipment and Supplies

<table>
<thead>
<tr>
<th>Item #</th>
<th>HCPCS Code</th>
<th>Description of DME/Medical Supplies</th>
<th>Quantity</th>
<th>Price</th>
<th>Prior Auth Required?</th>
<th>Beyond Quantity Limit?</th>
<th>Custom Item?</th>
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<td>28</td>
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<td>29</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. If “Yes”, additional documentation must be provided to support determination of medical necessity.

**Section B --- Diagnosis and Medical Need Information**

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

By signing this form, I hereby attest that the information completed in Section “A” is consistent with the determination of the client’s current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client’s home when used as prescribed.

Signature and attestation of prescribing physician: _____________________________ Date: ____/____/____

Prescribing Physician’s TPI number: _____________________________ Prescribing Physician’s LICENSE number: _____________________________

__Check if all of the information in Section “A” was complete at the time of prescribing provider signature. ___

Signature stamps and date stamps are not acceptable.

__Check if additional documentation is attached as outlined in the TMPPM. ___
## B.24 Home Health Services Plan of Care (POC) Instructions

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Last, First, MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid No:</td>
<td>Nine-digit number from client’s current Medicaid identification card.</td>
</tr>
<tr>
<td>DOB:</td>
<td>Date of Birth-month, day and year.</td>
</tr>
<tr>
<td>Date Last Seen By Doctor:</td>
<td>Client must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment.</td>
</tr>
<tr>
<td>Provider Name:</td>
<td>Name of home health agency.</td>
</tr>
<tr>
<td>TPI</td>
<td>Nine-character Texas Provider Identifier of agency whose suffix is for DMEH services.</td>
</tr>
<tr>
<td>Agency Phone No:</td>
<td>Area code and telephone number of agency.</td>
</tr>
<tr>
<td>Physician’s Name/Phone No/License No:</td>
<td>Name, area code/telephone number, and license # of client’s physician who is ordering home health services.</td>
</tr>
<tr>
<td>Status:</td>
<td>Indicate with a check mark if POC is for a new client, extension (services need to be extended for an additional 60 day period) or a revised request (POC for this authorization period is being revised).</td>
</tr>
<tr>
<td>Original SOC date:</td>
<td>First date of service in this 365 day benefit period.</td>
</tr>
<tr>
<td>Revised Request Effective Date:</td>
<td>Date revised services, supplies or DME became effective.</td>
</tr>
<tr>
<td>Services Client Receives From Other Agencies:</td>
<td>List other community or state agency services client receives in the home. Examples: primary home care (PHC), community based alternative (CBA), etc.</td>
</tr>
<tr>
<td>Diagnosis:</td>
<td>Diagnosis related to ordered home health services. For reimbursement, diagnoses must match those listed on the claim and be appropriate for the services ordered. (Include ICD-9 code if PT ordered)</td>
</tr>
<tr>
<td>Functional Limitations/Permitted Activities:</td>
<td>Include on revised request only if pertinent</td>
</tr>
<tr>
<td>Prescribed Meds:</td>
<td>List medications, dosages, routes, and frequencies (Include on revised request if applicable)</td>
</tr>
<tr>
<td>Diet Ordered:</td>
<td>Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (Include on revised request if applicable)</td>
</tr>
<tr>
<td>Mental Status:</td>
<td>Examples: Alert and oriented, confused, slow to learn etc. (Include on revised request if applicable)</td>
</tr>
<tr>
<td>Prognosis:</td>
<td>Examples: Good, fair, poor, etc. (Include on revised request if applicable)</td>
</tr>
<tr>
<td>Rehab Potential:</td>
<td>Potential for progress – Examples: Good, fair, poor etc. (Include on revised request if applicable)</td>
</tr>
<tr>
<td>Safety Precautions:</td>
<td>Examples: O2 safety, seizure precautions, etc. (Include on revised request if applicable)</td>
</tr>
<tr>
<td>Medical Necessity, Clinical Condition, Treatment Plan:</td>
<td>Describe medical reason for all services ordered, nursing observations pertinent to the plan of care, and the proposed plan of treatment. For PT, list specific modalities and treatments to be used.</td>
</tr>
<tr>
<td>SNV/HHA/PT/OT Visits Requested:</td>
<td>State the number of visits requested for each type of service authorized.</td>
</tr>
<tr>
<td>Supplies:</td>
<td>List all supplies authorized.</td>
</tr>
<tr>
<td>DME:</td>
<td>List each piece of DME authorized, check whether DME is owned or if DME is to be repaired, purchased or rented and for what length of time the equipment will be needed.</td>
</tr>
<tr>
<td>RN:</td>
<td>The signature/date form was completed by the RN who completed this form.</td>
</tr>
<tr>
<td>From/To Dates:</td>
<td>Dates (up to 60 days) of authorization period for ordered home health services.</td>
</tr>
<tr>
<td>Conflict of Interest Statement:</td>
<td>Relevant to the physician signing this form; physician should check box if exception applies.</td>
</tr>
<tr>
<td>Physician Signature/Printed Name/Date Signed/License Number:</td>
<td>Signature/date form signed by physician ordering home health services, physician printed name, and license number.</td>
</tr>
</tbody>
</table>
# B.25 Home Health Services Plan of Care (POC)

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

## Client Name:  
Provider Name:  

<table>
<thead>
<tr>
<th>Medicaid No:</th>
<th>DOB:</th>
<th>TPI:</th>
<th>DMEH TPI of HH Agency:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date last seen by Doctor:</th>
<th>Agency Phone No: (            )</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Physician’s Name:</th>
<th>Phone No:</th>
<th>License No:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Status: (Check One)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Client ☐</td>
<td>Extension ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Original SOC Date:</th>
<th>Revised Request Effective Date:</th>
<th></th>
</tr>
</thead>
</table>

## Services Client Receives from other agencies:

## Diagnoses (include ICD-9 codes if PT/OT is ordered):

## Function Limitations/Permitted Activities/Homebound Status:

## Prescribed Meds:

## Diet Ordered:  
Mental Status:  

## Prognosis:  
Rehab Potential:  

## Safety Precautions:

## Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):

## SNV Visits Requested:

## HHA Visits Requested:

## PT Visits Requested:

## OT Visits Requested:

## Supplies:

## DME Item #1:
- Own ☐  
- Repair ☐  
- Buy ☐  
- Rent ☐  
- How Long Needed?

## DME Item #2:
- Own ☐  
- Repair ☐  
- Buy ☐  
- Rent ☐  
- How Long Needed?

## DME Item #3:
- Own ☐  
- Repair ☐  
- Buy ☐  
- Rent ☐  
- How Long Needed?

## DME Item #4:
- Own ☐  
- Repair ☐  
- Buy ☐  
- Rent ☐  
- How Long Needed?

## RN Signature:  
Date Signed:  

I anticipate home care will be required From:  

To:  

## Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program.

Check if this exception applies. ☐ Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

## Physician Signature:  
Date Signed:  

Printed Physician Name:  
License Number:  

Office Use Only:
B.26 Home Health Services Prior Authorization Checklist

Contact Medicaid Home Health Services at 1-800-925-8957

To facilitate the authorization process, the home health agency nurse should have completed the following tasks before contacting TMHP for prior authorization of home health services:

- Completion of this optional form
- Evaluation of the client in the home (preferably by the same nurse requesting services)

PLEASE DO NOT SUBMIT THIS FORM TO TMHP.

Date: __________________________ Agency Nurse Name: __________________________
Client Medicaid Number: _______________ Client Name: __________________________
Client Medicare Number: _______________ Date Last Seen by Physician: _______________
Start of Care Date: ____________________ Date of Last Hospitalization: _________________
Date of Home Evaluation: ______________ Diagnoses: ____________________________________________________________________________

(If PT is requested, please provide ICD-9-CM diagnosis codes)

Skilled Nursing functions to be provided: ____________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Pertinent Nursing Observations (prior teaching, size and descriptions of wounds, functional limitations, etc.): ____________________________________________________________________________

________________________________________________________________________________________

Observations of home setting that may effect care (i.e. cleanliness, availability of running water, electricity and refrigeration, etc.): ____________________________________________________________________________

________________________________________________________________________________________

Availability and capability of caregiver(s): ____________________________________________________________________________

________________________________________________________________________________________

Services client receives from other sources (i.e. Primary Home Care): ____________________________________________________________________________

________________________________________________________________________________________

Services Requested: ___ Skilled Nursing Frequency ____________
___ Home Health Services Aide Frequency ____________
___ Physical Therapy Frequency ____________
___ DME ______ Repair ______ Rent ________ Purchase

__________Bid #1
__________Bid #2

___ Supplies: ____________________________________________________________________________

TMHP Nurse: __________________________ PAN: __________________________
PURPOSE: This form is to be used by HOSPITALS ONLY to report the birth of a child of a mother currently eligible under the Texas Medicaid Program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future Medicaid claims payments. If the child’s FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid Recipient number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child’s Medicaid claim.

To avoid delay in processing the child’s Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

<table>
<thead>
<tr>
<th>Mother’s Name (Last, First, MI)</th>
<th>Admission Date (mm/dd/yy)</th>
<th>Mother’s Medicaid Recipient No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s Mailing Address – Street</td>
<td>Mother’s D.O.B. (mm/dd/yy)</td>
<td>Mother’s Medical Record No.</td>
</tr>
<tr>
<td>City, State, ZIP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child’s Name (Last, First, MI)</th>
<th>Sex</th>
<th>Child’s DOB (mm/dd/yy)</th>
<th>Child’s Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s Name (Last, First, MI)</td>
<td>Sex</td>
<td>Child’s DOB (mm/dd/yy)</td>
<td>Child’s Medical Record No.</td>
</tr>
<tr>
<td>Child’s Name (Last, First, MI)</td>
<td>Sex</td>
<td>Child’s DOB (mm/dd/yy)</td>
<td>Child’s Medical Record No.</td>
</tr>
<tr>
<td>Has the mother relinquished her rights to the newborn child?</td>
<td>❑ Yes ❑ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If “Yes,” give date of relinquishment ............................................

<table>
<thead>
<tr>
<th>Child’s Attending Physician</th>
<th>Physician’s Medical License No.</th>
<th>TPI</th>
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</thead>
<tbody>
<tr>
<td>Hospital Name</td>
<td></td>
<td></td>
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<tr>
<td>Hospital Address—Street</td>
<td>Completed By (please type or print)</td>
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</tr>
<tr>
<td>City, State, ZIP</td>
<td>Hospital Telephone No.</td>
<td>Date Form Mailed</td>
</tr>
</tbody>
</table>

Texas Health and Human Services Commission
Data Integrity 952-X
PO BOX 149030
Austin TX 78714-9030

Date Rec’d in Integrity Control
B.28 Hysterectomy Acknowledgment Form

MEDICAID CLIENT IDENTIFICATION NUMBER    / / / / / / / / / / / / /

Hysterectomy Acknowledgment

I hereby acknowledge that I was, prior to surgery ________________ (month, day, year), informed both orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom that procedure is performed permanently incapable of bearing children.

________________________________________ __________________
Signature of Client or Designated Representative Date

Reconocimiento

Yo afirmo haber sido informada verbalmente y por escrito, antes de la cirugía ________________ (mes, día, año) que una histerectomía (extracción quirúrgica del útero) dejará a la persona a la cual se haya operado permanentemente, incapaz de tener hijos.

________________________________________ ___________________
Firma del Cliente o Representante Designado Fecha

Interpreter’s Statement

To be used if an interpreter is provided to assist the individual having the hysterectomy.

I have translated to the individual having a hysterectomy the information and advice presented orally by the individual obtaining consent. I have also read the consent form to _________________________ in ________________________ language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

________________________________________ ___________________
Signature of Interpreter Date

Revised 8/22/95
B.29 Informational Inquiry Form

Today's Date

Client Information

Medicaid Number
Date of Birth
SSN
First/Last Name

Accident Information

Date of Loss
Type of Accident

Attorney Information

Name
Contact Name
Address
City/State/ZIP Code
Phone
Fax

Insurance Information

Name
Contact Name
Address
City/State/ZIP Code
Phone
Fax
Ins. Claim Number

Provider Information

Name
TPI Number
Address
City/State/ZIP Code
Phone
Fax

Mail completed form to:
HHSC/OIG/TPR Unit
INFOC
PO Box 85200
Austin, TX 78708-5200
B.30 Medicaid Audit Request for Claims Summary

PROVIDER NAME:

TEXAS PROVIDER IDENTIFIER (TPI):

Tentative Settlement Claims Summary for Period Beginning:

and Ending:

Requesting:

Paper Copy □

or

Microfiche □

Final Settlement Claims Summary for Period Beginning:

and Ending:

Requesting:

Paper Copy □

or

Microfiche □

MAIL TO:

ATTN:
## B.31 Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices (High-Frequency Chest Wall Compression System [HFCWCS]; Intrapulmonary Percussive Ventilation Device [IPV]; Cough-Stimulating Device [Cofflator]) - Initial Request

### Section A:
To be completed by the physician or physician staff

<table>
<thead>
<tr>
<th>Client name</th>
<th>_______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Medicaid #</td>
<td>___________________________</td>
</tr>
<tr>
<td>Client primary diagnosis</td>
<td>___________________________</td>
</tr>
<tr>
<td>Client respiratory diagnosis</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician name</th>
<th>___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Texas Medical license #</td>
<td>___________</td>
</tr>
<tr>
<td>Physician phone #</td>
<td>___________________________</td>
</tr>
<tr>
<td>Physician Fax #</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

### Section B:
To be completed by the physician

- **Device requested:** HFCWCS (ThAIRapy)  IPV  Cofflator (circle)

  - Client had respiratory illness or complication in past 6 months (Yes _________ No _________)
    - Provide additional information in narrative section (i.e. nebs for respiratory secretions, I.V. antibiotics, hospitalizations)
  - Client or family unable to do chest physiotherapy (Yes _________ No _________)
    - Medical reasons in narrative section
  - Client has tried other modes of chest physiotherapy, including the percussor or flutter valve (Yes _________ No _________)
    - Medical reasons in narrative section
  - Client had pulmonary function studies in last 6 months, if applicable (Yes _________ No _________)
  - Client has frequently missed work/school in last 6 months due to respiratory illnesses and ineffective chest physiotherapy (Yes _________ No _________)

Clients can have only one system at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the **Texas Medicaid Provider Procedures Manual**, Section 25.

### Section C:
The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.

**Narrative note for medical necessity (write legibly):**

<table>
<thead>
<tr>
<th>Physician Signature</th>
<th>___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

Submit with Completed Title XIX
### Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices

#### (High-Frequency Chest Wall Compression System [HFCWCS]; Intrapulmonary Percussive Ventilation Device [IPV]; Cough-Stimulating Device [Cofflator]) - Extended Request

<table>
<thead>
<tr>
<th>Section A:</th>
<th>To be completed by the physician or physician staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client name</td>
<td>_______________________________</td>
</tr>
<tr>
<td>Client Medicaid #</td>
<td>___________________________</td>
</tr>
<tr>
<td>Client primary diagnosis</td>
<td>____________________________________</td>
</tr>
<tr>
<td>Client respiratory diagnosis</td>
<td>____________________________________</td>
</tr>
<tr>
<td>Physician name</td>
<td>__________________________</td>
</tr>
<tr>
<td>Physician Texas Medical license #</td>
<td>____________</td>
</tr>
<tr>
<td>Physician phone #</td>
<td>__________________________</td>
</tr>
<tr>
<td>Physician fax #</td>
<td>__________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section B:</th>
<th>To be completed by the physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Device requested: HFCWCS (ThAIRapy) IPV Cofflator (circle)</td>
<td></td>
</tr>
<tr>
<td>Client had respiratory illness or complications since initial authorization (include additional information in narrative section i.e. nebs for respiratory secretions, I.V. antibiotics, hospitalizations)</td>
<td>Yes _________ No _________</td>
</tr>
<tr>
<td>Client has been compliant in use of device (document minutes logged per treatment, times per day of treatments and # of days used for entire trial period)</td>
<td>Yes _________ No _________</td>
</tr>
<tr>
<td>Client has achieved the desired health outcome with device</td>
<td>Yes _________ No _________</td>
</tr>
</tbody>
</table>

Clients can have only one system at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the *Texas Medicaid Provider Procedures Manual, Section 25.*

Section C: The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.

**Narrative note for medical necessity (write legibly):**

Physician Signature____________________________________________Date______________________

Submit with Completed Title XIX
B.33 Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy

**SECTION A**

<table>
<thead>
<tr>
<th>Client Name: ___________________________</th>
<th>Client Medicaid #: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Name: _________________________</td>
<td>Physician Provider #: _________________________</td>
</tr>
<tr>
<td>Physician Phone #: ______________________</td>
<td>Physician License #: _________________________</td>
</tr>
<tr>
<td>Supplier name and Address: ___________________________</td>
<td></td>
</tr>
<tr>
<td>Medicaid Number: _________________________</td>
<td>Phone and Fax number: _________________________</td>
</tr>
</tbody>
</table>

**SECTION B**

**CPAP/BiPAP S REQUEST:**

- Diagnosis: ____________________________________________________________
- Date of Polysomnogram: __________________
- If request is for BiPAP, explanation of inability to tolerate CPAP: ____________________________________________________________
- AHI/RDI: ___________ Sleep Time: _________ hrs Total Apneas: ___________
- Obstructive apneas: ___________ Lowest Oxygen Saturation: ___________ %

**BIPAP ST REQUEST:**

- Diagnosis: ____________________________________________________________
- Date of Polysomnogram: __________________
- Lowest Oxygen Saturation: ___________ % OR Arterial PO2: ___________ mm Hg
- If prescribed for central apnea: Central apneas/hr: ___________ Longest central apnea: ________ sec.

**OXYGEN THERAPY REQUEST:**

- Lowest Oxygen Saturation at rest or with exercise: ___________ % OR Arterial PO2: ___________ mm Hg
- Lowest Oxygen Saturation during sleep: ___________ % OR Arterial PO2: ___________ mm Hg
- Flow rate: ___________ l/min Hours of treatment per day: ___________ (estimated)
- Is oxygen therapy required for mobility within the home? Yes: ________ No: ________
- Prescribing physician: ___________________________ Signature: ___________________________ Date: ___________________________

Must be submitted with a completed Title XIX form.
B.34 Medicaid Certificate of Medical Necessity for Reduction Mammaplasty

Section A: To be completed by the physician or physician staff

Client name ___________________________________  Physician name ________________________________
Client Medicaid # ______________________________  Physician Texas medical license #___________________
Client date of birth ______________________________  Physician phone #______________________________
Client ht. and wt. ________________________________  Physician fax # ________________________________
Client breast size________________________________  Physician TPI # ______________________________
(must include photograph)

Section B: To be completed by the Physician

☐ Client has evidence of a restrictive pulmonary defect.   Yes ______   No ______
   (provide results of pulmonary function studies in narrative section)
☐ Client has evidence of severe neck and back pain.    Yes ______   No ______
   (provide results of therapies tried in narrative section)
☐ Client has evidence of ulnar paresthesia from thoracic nerve root compression.
   Yes ______   No ______
   (provide results of therapies tried in narrative section)
☐ Client has evidence of ischemic heart disease.                          Yes ______   No ______
   (provide results of abnormal EKG and/or coronary angiography)
☐ This client, if age 40 or over, has had a mammogram within the past year that was negative for cancer.
   Yes ______   No ______
☐ Estimated the grams of breast tissue to be removed from each breast.
   Rt. ______   Lt. ______
☐ The client is in a weight reduction program and has lost ______ lbs.   Yes_______   No ______

Section C: Physician prescribing Reduction Mammaplasty must complete narrative information regarding the medical necessity as requested above.

Narrative note for medical necessity:

_______________________________  ________________________
Physician signature Date

Refer to the Reduction Mammaplasty policy in the Texas Medicaid Provider Procedures Manual, section 36.
B.35 Nursing Addendum to Plan of Care (THSteps-CCP) (3 Pages)

Client’s Name: ___________________________ Medicaid #: ______________________ Date: ________________

In accordance with the PDN adopted rules (Chapter 33 Early and Periodic Screening, Diagnosis and Treatment, Subchapter K. Private Duty Nursing) published in the Texas Register, December 25, 1998 (23TexReg 13077), the following criteria must be met for the authorization of PDN Services. Caregivers and alternate caregivers must also be identified for authorization to proceed.

- The client has an identified primary caregiver who provides some of the client’s daily care:
  (Caregiver) Name ___________________________ Relationship ______ Phone # __________

- The client has a designated alternate caregiver or a plan if the primary caregiver is unable to provide care:
  (Alternate) Name ___________________________ Relationship ______ Phone # __________

- The client has a primary physician who provides ongoing health care and medical supervision.

- The place(s) where PDN services will be delivered supports the health and safety of the client.

- If applicable, there are necessary backup utilities, communication, fire and safety systems available and functional.

DOCUMENTATION REQUIREMENTS: (1) All components of the Addendum must be complete and submitted with the (2) physician’s plan of care (POC) and (3) THSteps-CCP Prior authorization request to the Texas Medicaid & Healthcare Partnership (TMHP) before PDN services can be authorized. All documents must be complete and received by TMHP before review or authorization. [Additional information may be attached.]

1) Nursing care plan summary: PDN services are based on a nursing assessment and nursing care plan established by the nurse provider in collaboration with the physician, client, and family. The nursing care plan provides a systematic way to document care given, client responses to interventions, and progress toward the goals of care.

<table>
<thead>
<tr>
<th>Problem List</th>
<th>Goals of Care</th>
<th>Specific Measurable Outcomes</th>
<th>Progress toward Goals</th>
</tr>
</thead>
</table>

Additional Comments:

Client’s Name: ___________________________ Medicaid #: ______________________ Date: __________________
2) Summary of recent health history for initial authorization OR 90 day summary for extension of PDN services:
Include recent hospitalizations, emergency room visits, surgery (may submit a discharge summary), illnesses, changes in condition, changes in medication or treatment, family/caregiver update, other pertinent observations.

3) Rationale for PDN hours to either increase, decrease, or stay the same. Also address plans to decrease PDN hours:
4) Schedule of services, including PDN and family/caregiver coverage and coverage from other resources:
(Codes: N=PDN hours, P=family/caregiver hours, S=School/Daycare, O=other in-home resource(s), specify name below)

<table>
<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thur</th>
<th>Fri</th>
<th>Sat</th>
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</table>

List other in-home resources:________________________________________________________________________

5) Acknowledgement (must be signed by the primary caregiver and the nurse provider):

By signing this form, the primary caregiver and the nurse provider acknowledge:

- Discussion and receipt of information about the THSteps-CCP Private Duty Nursing service,
- PDN services may increase, decrease, stay the same, or be terminated based on a client’s need for skilled care,
- PDN is not authorized for respite, child care, activities of daily living, or housekeeping,
- All required criteria from the first page of this addendum are met, and completed documentation is submitted to TMHP,
- Participation in the development of the Nursing Care Plan for this client, and
- Emergency plans are part of the client’s care plan and include telephone numbers for the client’s physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations.

The primary caregiver agrees to follow through with the Plan of Care as prescribed by the client’s physician. The primary caregiver agrees to learn all the skills necessary to provide care for the child in the absence of a private duty nurse.

The number of PDN hours requested is ______hrs/day OR _____hrs/week for the dates of service from ______________ to _________________.

____________________________________ ___________________________
Signature of Primary Caregiver/Printed Name Date

________________________________________________ ___________________________
Signature of PDN Nurse Provider/Printed Name Date
B.36  Other Insurance Form

Client Name: ________________________________________________________________________________
Client Medicaid Number: _______________________________________________________________________
Insurance Company Name: _____________________________________________________________________
Insurance Company Address: ___________________________________________________________________
Insurance Company Phone #: ___________________________________________________________________
Policy Holder Name: ___________________________________________________________________________
Policy Holder SSN: _____________________________________________________________________________
Employer Name: ______________________________________________________________________________
Group Number: _______________________________________________________________________________
Ins. Eff. Date: _____________________________ Ins. Term. Date: _____________________________
List any family members and their SSN or Medicaid ID numbers that are covered under this policy: _______
____________________________________________________________________________________________
____________________________________________________________________________________________
COMMENTS: _________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
CONTACT: TMHP Third Party Resources (TPR) 1-800-846-7307
            TMHP Third Party Resources (TPR) fax 1-512-514-4225
MAIL CORRESPONDENCE: Texas Medicaid & Healthcare Partnership
            TPR Correspondence
            Third Party Resources Unit
            PO Box 202948
            Austin, TX 78720-9981
B.37 Primary Care Case Management (PCCM) Behavioral Health Consent Form

DIRECTIONS: This is an authorization for the release of information to your primary care provider.

PLEASE FILL OUT THE INFORMATION BELOW:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City, State</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

authorize: ______________________________________________________________________________________________

Provider Name

to disclose: ______________________________________________________________________________________________

Provider Name

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

City, State

from (date) ______________________________  to (date) ________________________________

Please indicate what, if any, information you would like to release.

☐ Total Medical Records to be released to primary care provider
☐ Medication Information Only to be released to primary care provider
☐ Medical Records to health plan

I understand that my records are protected under Federal (42 CFR Part 2) and/or State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. File copy is considered equivalent to the original. This release of information expires in thirty (30) days or sixty (60) days following completion or termination of treatment, whichever is later.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

EXECUTED THIS ______________  DAY OF ______________

__________________________________________  _________________________________________________

(Witness) (Patient)

_________________________________________________

(Parent, Guardian, or Authorized Representative, if required)

The person signing this authorization is entitled to a copy.

TO THE INDIVIDUAL FILLING THIS OUT:
You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method for asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact the Texas Medicaid & Healthcare Partnership (TMHP). You can write to the Texas Medicaid & Healthcare Partnership (TMHP), Attention: State Action Request Support Manager, MC-C04, P.O. Box 204270, Austin, TX 78720-4270. You can also call the Texas Medicaid & Healthcare Partnership PCCM Client Helpline at 1-888-302-6688.

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION, PROHIBITION ON DISCLOSURE:
If the information disclosed to you is related to substance abuse treatment, these records’ confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient’s records.
### INSTRUCCIONES. Esta es una autorización para la divulgación de información para su Proveedor de Cuidado Primario.

<table>
<thead>
<tr>
<th>POR FAVOR, DÉ LA SIGUIENTE INFORMACIÓN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yo, __________________________________________________________________________________</td>
</tr>
<tr>
<td>Nombre</td>
</tr>
<tr>
<td>Ciudad, Estado</td>
</tr>
<tr>
<td>autorizo a: ___________________________________________________________________________</td>
</tr>
<tr>
<td>Nombre del proveedor</td>
</tr>
<tr>
<td>ciudad, Estado</td>
</tr>
<tr>
<td>para que le dé a: ______________________________________________________________________</td>
</tr>
<tr>
<td>Nombre del proveedor</td>
</tr>
<tr>
<td>Ciudad, Estado</td>
</tr>
<tr>
<td>la siguiente información de (fecha) ____________ a (fecha) _______________________________</td>
</tr>
<tr>
<td>Por favor, indique qué información quiere divulgar, si es que quiere divulgar alguna.</td>
</tr>
</tbody>
</table>

- [ ] Todos los expedientes médicos se pueden divulgar al Proveedor de Cuidado Primario
- [ ] Sólo la información sobre medicamentos se puede divulgar al Proveedor de Cuidado Primario
- [ ] Los expedientes médicos se pueden divulgar al plan de salud

Entiendo que mis expedientes están protegidos bajo Normas de Confidencialidad Estatales y Federales (42 CFR Parte 2). Esta autorización puede revocarse por escrito en cualquier momento, excepto en el caso en que el programa o la persona que hará la divulgación haya dependido de ella para tomar una acción. Al revocar la autorización, la divulgación adicional de información se detendrá inmediatamente. Las copias de archivo se consideran equivalentes al original. Esta autorización para divulgar información se vence en treinta (30) o sesenta (60) días después de que se termine o se suspenda el tratamiento, el que se llegue después.

También reconozco que se me explicó detalladamente la información que se divulgará y que doy este consentimiento por mi propia voluntad.

FIRMADO ESTE DÍA ______ DE ________________

(Primer) (Paciente)

(Padre, Tutor o Representante Autorizado, si se exige)

La persona que firma esta autorización tiene derecho a una copia.

---

**PARA LA PERSONA QUE LLENA ESTE FORMULARIO:**
Tiene el derecho de hacernos preguntas sobre este formulario. También tiene el derecho de revisar la información que nos da en el formulario. (Hay algunas excepciones). Si la información está incorrecta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Puede encontrarlo en el Título 1 del Código Administrativo de Texas, Secciones 351.17 a 351.23. Para hablar con alguien acerca de esta forma, o para pedir correcciones, haga el favor de comunicarse con Texas Medicaid & Healthcare Partnership (TMHP), Puede comunicarse con el personal de Texas Medicaid & Healthcare Partnership (TMHP), Atención: State Action Request Support Manager, MC-C04, P.O. Box 204270, Austin, TX 78720-4270. También puede llamar a la Línea de Ayuda al Cliente de PCCM, 1-888-302-6688.

**PARA LA PERSONA QUE RECIBE LA INFORMACIÓN CONFIDENCIAL:** PROHIBICIÓN SOBRE LA DIVULGACIÓN
Si la información que usted ha recibido tiene que ver con el tratamiento para el abuso de sustancias, la ley federal protege la confidencialidad de estos expedientes. Las reglas federales (42 CFR Parte 2) le prohíben a usted hacer cualquier otra divulgación de estos expedientes sin el consentimiento escrito específico de la persona de quien se tratan, o de otra manera permitida por dichas normas. Una autorización general para la divulgación de información médica o de otro tipo no es suficiente para divulgar expedientes relacionados con el abuso de sustancias. Las reglas federales limitan el uso de la información a investigar o enjuiciar penalmente a algún paciente de abuso de sustancias. Es posible que las leyes estatales también protejan la confidencialidad de los expedientes del paciente.
## B.39 Primary Care Case Management (PCCM) Community Health Services Referral Request Form

<table>
<thead>
<tr>
<th>PCP INFORMATION</th>
<th>CLIENT INFORMATION</th>
<th>CLIENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
<td>Client Name:</td>
<td>Client Name:</td>
</tr>
<tr>
<td>TPI Number:</td>
<td>Medicaid ID#:</td>
<td>Medicaid ID#:</td>
</tr>
<tr>
<td>Contact Name:</td>
<td>Phone Number:</td>
<td>Phone Number:</td>
</tr>
<tr>
<td>Phone Number:</td>
<td>Reason for Referral:</td>
<td>Reason for Referral:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Appointment No Show</td>
<td>[ ] Appointment No Show</td>
</tr>
<tr>
<td></td>
<td>[ ] Abuse of Doctor/Staff</td>
<td>[ ] Abuse of Emergency Room</td>
</tr>
<tr>
<td></td>
<td>[ ] Treatment Plan Adherence</td>
<td>[ ] Treatment Plan Adherence</td>
</tr>
<tr>
<td>Case Management/Health Education Needs:</td>
<td>Case Management/Health Education Needs:</td>
<td></td>
</tr>
<tr>
<td>[ ] Asthma</td>
<td>[ ] Childhood Illness</td>
<td>[ ] Community Resources</td>
</tr>
<tr>
<td>[ ] Cardiac</td>
<td>[ ] Nutrition</td>
<td>[ ] Transportation</td>
</tr>
<tr>
<td>[ ] Dental</td>
<td>[ ] Parenting</td>
<td>[ ] Behavioral Psych</td>
</tr>
<tr>
<td>[ ] Diabetes</td>
<td>[ ] Prenatal</td>
<td>[ ] Disorder</td>
</tr>
<tr>
<td>[ ] Exercise</td>
<td>[ ] Tobacco Use</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Child/Adult with Special Health Care Needs</td>
<td>[ ] Other:</td>
<td></td>
</tr>
<tr>
<td>[ ] Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For Primary Care Case Management Clients Only
Fax to Community Health Services at (512) 302-0318
Referrals are also received by telephone at 1-888-276-0702 (M-F, 8 a.m. to 5 p.m., CST)
B.40 Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form

This form is used to obtain prior authorization (PA) for elective inpatient admission/procedures and outpatient services, update an existing inpatient or outpatient authorization and provide notification of emergency admissions.

Phone: 1-888-302-6167 (Option 1 Inpatient, Option 2 Outpatient) Fax: 1-512-302-5039

Please check the appropriate action you are requesting

**Inpatient Services:**
- Notification (complete fields in Sec 1 excluding clinical documentation)
- DRG or clinical update (complete Sec 2)
- Non Routine OB/NB (complete Sec 1)
- Prior Authorization of scheduled admission/procedure (complete Sec 1)

**Outpatient (OP) Services:**
- Prior authorization for outpatient services (complete Sec 1)
- Update/change codes from original OP PA request (complete Sec 2)

Facility TPI #: __________________________ Facility Name: ___________________________ Reference # (if available)________

PCN #: __________________________ Client Name: ___________________________ DOB: ____________________________

Requesting (Admitting) Physician TPI #: __________________________ Requesting (Admitting) Physician Name: ____________________________

Form Completed by: __________________________ Date Completed: ____________________________

Phone #: __________________________ Fax #: ____________________________

Section 1
Service Type:  □ Outpatient Service(s)  □ Emergent/Urgent Admit  □ Scheduled Admission/Procedure  □ Admit Following Observation

Date of Service: __________________________ Procedure Code(s): ____________________________

Diagnosis Codes: Primary - __________________________, Secondary - __________________________, __________________________, __________________________, __________________________, __________________________, __________________________

*DRG Code: __________________________ Discharge Date (if available): ____________________________

Clinical Documentation Supporting Medical Necessity for a scheduled admission/procedure, outpatient services or non-routine OB/NB:

__________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________

Section 2 Updated Information (When necessary)

Diagnosis Code(s): Primary - __________________________ Secondary - __________________________, __________________________, __________________________

Date of Service: __________________________ Procedure Code(s): __________________________ *DRG Code: __________________________

Clinical Documentation to Support Medical Necessity of DRG or Procedure Code Change:

__________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________

*Only required for DRG inpatient admission
**B.41 Primary Care Case Management (PCCM) Referral Form**

### PCP INFORMATION

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Texas Provider Identifier (TPI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Name and Phone Number</td>
<td></td>
</tr>
</tbody>
</table>

### CLIENT INFORMATION

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Date of Birth</th>
<th>Provider Signature</th>
<th>Referral Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client’s Medicaid Number</td>
<td>Phone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### REFERRING PROVIDER INFORMATION (If different from PCP)

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Texas Provider Identifier (TPI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Name and Phone Number</td>
<td></td>
</tr>
</tbody>
</table>

### CONSULTING PROVIDER/FACILITY

<table>
<thead>
<tr>
<th>Provider/Facility Name</th>
<th>Medicaid Provider # (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>Phone</td>
</tr>
</tbody>
</table>

### Reason for Referral:

### TO THE CONSULTANT

This notice authorizes the following care:

- [ ] Evaluation Only
- [ ] Evaluation and Single Treatment
- [ ] Evaluation and Treatment

Number of Treatments: ____

Initial consultations are for one visit only for evaluation and development of a treatment plan unless otherwise specified. All consultations require a written report (preferably typed and attached to this form) to the PCP and phone conferences as necessary to assure continuity of care. Referrals are valid for 30 days from the time of issue and it is the consulting provider’s responsibility to verify eligibility prior to delivering services. Consulting providers may not authorize secondary referrals. All requests for additional services or visits to other providers must come through the PCP. All claims are subject to retrospective review for purposes of determining eligibility, benefit coverage, appropriateness, and medical necessity. Claims payment may be affected by review findings.

Consultant Comments:

________________________________________________________________________

________________________________________________________________________

Consultant Signature: ___________________________ Date: / /  

Please return findings and report to PCP listed above.

Revised May 2005
### B.42 Primary Care Case Management (PCCM) Pre-Contractual/Recredentialing Site and Medical Record Evaluation

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Meets Criteria</th>
<th>Comments (include provider’s comments regarding any criteria not met)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Appearance:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Appears Clean</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>2) Signage Clearly Visible</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>3) In Good Repair</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>4) Not Odorous</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>5) Adequate Seating</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>6) Good Visibility from Reception Area</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td><strong>Office Space:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) Rest Rooms Available</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>8) Rest Rooms Adequate</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>9) Rest Room(s) Wheelchair Accessible</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>10) Number of Exam Rooms Adequate</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>11) Exam Rooms Well-Equipped</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td><strong>Emergency Preparedness:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12) Emergency Equipment Available</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>13) Staff Knowledgeable of Equipment</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>14) Staff Trained in CPR</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td><strong>Safety:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17) Smoke Alarms</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>18) Fire Extinguisher</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>19) Exit Signs</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>20) Passageways Clear</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td><strong>Handicapped Access:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21) Wheelchair Ramp</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>22) Wide Doors</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>23) Elevators (N/A if Single Story)</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td><strong>Staff:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24) Courteous</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>25) Answer Phones Promptly</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>26) Appear Knowledgeable</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>27) Neat/Well Groomed</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td><strong>Medical Records:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28) Individual Charts for Each Client</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>29) Stored in Dedicated Space</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>30) Personal/Biographical Data Present</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>31) Provider Identification &amp; Date</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>32) Legible</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>33) Allergies Noted Prominently</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>34) Health Ed/Preventive Svcs Noted</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>35) Advance Directives Offered (Adults)</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
<tr>
<td>36) Confidentiality Maintained</td>
<td>☐ ☐</td>
<td>COP</td>
</tr>
</tbody>
</table>

**ADDENDUM LEP QUESTION:** Do you have access to translation services if needed for clients with limited English language skills? ☐ ☐ **Offer phone #s for translation services if needed**
B.43 Physician’s Examination Report

<table>
<thead>
<tr>
<th>Client Name (Last, First, M)</th>
<th>Client No.</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street, City, State, ZIP Code)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Date Of Examination*

2. Ear Examination:
   a. Within Normal Limits
      ☐ Yes  ☐ No
   b. Cerumen Removed
      ☐ Yes  ☐ No
   c. Describe Ear Abnormalities:

3. Is more otolaryngological examination/treatment required to provide medical clearance for the fitting of a hearing aid? ☐ Yes ☐ No

   *If yes, refer this patient for consultation and completion of this form.

4. Are there any medical contradictions to hearing aid usage in either ear? ☐ Yes ☐ No

   *If yes, a hearing aid is medically prohibited in ☐ Right Ear ☐ Left Ear

5. Is the above-named individual a candidate for a hearing aid evaluation? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Signature* - Physician</th>
<th>Physician’s Name (please type or print)</th>
<th>Medical Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td>Telephone No.</td>
</tr>
</tbody>
</table>

*NOTE PLEASE FURNISH THE PATIENT WITH THE SIGNED AND DATED ORIGINAL AND ONE COPY OF THIS FORM

To be reimbursed for the examination, you must submit this completed form along with a claim for physician’s services to the following address:

Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, TX 78727
B.44  Physician’s Medical Necessity Certification for Nonemergency Ambulance Transports (Texas Medicaid Program)

| Request Date: __________/__________/ __________ | Transport Date: __________/__________/ __________ |
| Patient’s Name:                                   | Medicaid Number:                                      |
| Transported From:                                 | Transported To:                                       |
| Physician’s Printed Name:                         | Physician License #:                                 |

In order for ambulance services to be covered, they must be medically necessary and reasonable. Medical necessity is established when the patient’s condition is clinically considered severely disabled and as such that transportation by any other means (including services provided through the Medicaid Medical Transportation Program or through that which is included in the rate for Long Term Care - Nursing Facilities) is contraindicated. A round-trip transport from the client’s home to a scheduled medical appointment (e.g., an outpatient or freestanding dialysis or radiation facility) is covered when the client meets the definition of severely disabled.

The HHSC Medicaid Program has defined “severely disabled” as that client’s physical condition limits mobility and requires the client to be bed-confined at all times, unable to sit unassisted at all times, or requires continuous life-support systems (including oxygen or IV infusion).

Please complete the questions below in order for the authorization to be evaluated under Medicaid coverage criteria.

1. Is the patient severely disabled as defined by the above definition?  [ ] Yes  [ ] No

2. If no, this client does not qualify for nonemergency ambulance transport.

3. If yes, please check the appropriate medical condition listed below.

- Requires continuous oxygen and monitoring by trained staff
- Requires airway monitoring or suction
- Requires restraints or sedation (MUST BE EXPLAINED IN OTHER)
- Comatose and requires trained monitoring
- Is actively seizure-prone and requires trained monitoring
- Had to remain immobile because of a fracture/possibility of a fracture that had not been set
- Patient is ventilator-dependent
- Contractures (MUST BE EXPLAINED IN OTHER)
- Has advanced decubitus ulcers and requires wound precautions (MUST BE EXPLAINED IN OTHER)
- Requires isolation precautions (VRE, MRSA, etc.) (MUST BE EXPLAINED IN OTHER)
- Patient requires continuous IV therapy
- Requires cardiac monitoring
- Is exhibiting signs of a decreased level of consciousness (MUST BE EXPLAINED IN OTHER)
- Total hip replacement requires hip precautions and cannot sit safely (MUST BE EXPLAINED IN OTHER)
- Other (explain)

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE AND ACCURATE AND SUPPORTED IN THE MEDICAL RECORD OF THE PATIENT. THE INFORMATION BEING UTILIZED ON THIS FORM IS BEING GATHERED TO ASSIST IN SEEKING REIMBURSEMENT FOR A NONEMERGENCY AMBULANCE TRANSPORT FROM THE MEDICAID PROGRAM. I UNDERSTAND THAT ANY INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION, WHICH LEADS TO INAPPROPRIATE PAYMENTS, ARE SUBJECT TO INVESTIGATIONS UNDER APPLICABLE FEDERAL AND STATE LAWS. * THIS AUTHORIZATION WILL BE VALID FOR 180 DAYS FROM THE DATE OF ISSUANCE AND WILL CERTIFY THAT THE PATIENT REMAINS SEVERELY DISABLED FOR THAT PERIOD OF TIME.

Signature of Attending or Patient’s Personal Physician – __________/__________/ __________ Date Signed

Requesting Provider ____ TPI

Fax #
B.45 Private Pay Agreement

I understand ____________ (Provider Name) ____________ is accepting me as a private pay patient for the period of ________________, and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Signed: ______________________________________________________

Date: _________________________________________________________
B.46 Provider Information Change Form Instructions

Signatures:
- The provider’s signature is required on the Provider Information Change Form for any and all changes requested for individual provider numbers.
- A signature by the authorized representative of a group or facility is acceptable for requested changes to group or facility provider numbers.

Address:
- Performing providers (physicians performing services within a group) may not change accounting information.
- For Traditional Medicaid, changes to the accounting or mailing address require a copy of the W9 form.
- For Traditional Medicaid, a change in ZIP code requires copy of the Medicare letter.

Tax Identification Number (TIN):
- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers cannot change the TIN.

General:
- Forms will be returned unprocessed if the nine-digit provider number is not indicated on the Provider Information Change Form.
- The W-9 form is required for all name and TIN changes.
- Mail or fax the completed form to:
  Texas Medicaid & Healthcare Partnership (TMHP)
  Provider Enrollment MC-B05
  PO Box 200795
  Austin, TX 78720-0795
  Fax: 1-512-514-4214
B.47 Provider Information Change Form

Traditional Medicaid, Children with Special Health Care Needs (CSHCN), and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

Check the box to indicate a PCCM Provider 

<table>
<thead>
<tr>
<th>9-digit Texas Provider Identifier (TPI):</th>
<th>Date:</th>
<th>Provider Name:</th>
</tr>
</thead>
</table>

List any additional TPIs that use the same provider information:

<table>
<thead>
<tr>
<th>TPI: ____________________</th>
<th>TPI: ____________________</th>
<th>TPI: ____________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TPI: ____________________</th>
<th>TPI: ____________________</th>
<th>TPI: ____________________</th>
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<table>
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<tr>
<th>TPI: ____________________</th>
<th>TPI: ____________________</th>
<th>TPI: ____________________</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>TPI: ____________________</th>
<th>TPI: ____________________</th>
<th>TPI: ____________________</th>
</tr>
</thead>
</table>

Physical Address* | Accounting/Mailing Address** | Secondary Address

<table>
<thead>
<tr>
<th>City:</th>
<th>City:</th>
<th>City:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>State:</th>
<th>ZIP:</th>
<th>State:</th>
<th>ZIP:</th>
<th>State:</th>
<th>ZIP:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone: (   )</th>
<th>Phone: (   )</th>
<th>Phone: (   )</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Fax:</th>
<th>Fax:</th>
<th>Fax:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Email:</th>
<th>Email:</th>
<th>Email:</th>
</tr>
</thead>
</table>

Type of Change: (Check the appropriate box below.)

- [ ] Change of physical address, telephone, and/or fax number
- [ ] Change of billing/mailing address, telephone, and/or fax number
- [ ] Change/Add secondary address, telephone, and/or fax number
- [ ] Change of provider status (e.g., termination from plan, moved out of area, specialist) 
  Explain in the Comments field
- [ ] Other (e.g., panel closing, capacity changes, and age acceptance)

Comments:

Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

<table>
<thead>
<tr>
<th>Tax ID Number:</th>
<th>Effective Date:</th>
</tr>
</thead>
</table>

Exact name reported to the IRS for this Tax ID:

The signature and date are required or the form will not be processed.

Provider Signature: Date:

Mail or fax the completed form to:

<table>
<thead>
<tr>
<th>Texas Medicaid &amp; Healthcare Partnership (TMHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Enrollment MC-B05</td>
</tr>
<tr>
<td>PO Box 200795</td>
</tr>
<tr>
<td>Austin, TX 78720-0795</td>
</tr>
</tbody>
</table>

* The physical address cannot be a PO Box. Traditional Medicaid providers who change their ZIP code must submit a copy of the Medicare letter along with this form.

** All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.
# B.48 Psychiatric Hospital Inpatient Admission Form

12365-A Riata Trace Parkway  
Austin, Texas 78727-6422  
TMHP CCIP  
Phone: 800-213-8877  
Fax: 512-514-4211

## I. Identifying Information

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid #:</td>
<td>Date:</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>Last name:</td>
<td>First name:</td>
<td>Middle initial:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Age:</td>
<td>Sex:</td>
<td>Date of admission:</td>
<td>Time:</td>
</tr>
<tr>
<td>Facility name:</td>
<td>Provider #:</td>
<td>Name of contact person:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commitment Type:</td>
<td>Effective Date:</td>
<td>County:</td>
<td>Judge:</td>
<td></td>
</tr>
</tbody>
</table>

### Referral source:
- [ ] Admitting MD  
- [ ] MH Professional  
- [ ] DPRS  
- [ ] Other (list):

### Current living arrangements:
- [ ] With parent(s)  
- [ ] Group/foster home  
- [ ] Other (list):

## IIA. Primary symptom described in “specific observable behavior” that requires acute hospital care:

(Include: Precipitating events leading to admission)

## IIB. Other relevant clinical information, including inability to benefit from less restrictive setting:

(Attach additional pages or documents, as necessary)

## IIC. Psychiatric medications (Include total daily dose)

<table>
<thead>
<tr>
<th>Name of chemical</th>
<th>Current use?</th>
</tr>
</thead>
</table>

## IID. Present and past drug/alcohol usage:

<table>
<thead>
<tr>
<th>Name of chemical</th>
<th>Current use?</th>
</tr>
</thead>
</table>

## IIE. Past psychiatric treatment

1. Number of previous inpatient admissions: [
2. Dates of most recent inpatient stay: / to /

2. Previous ambulatory/outpatient treatment (provider or facility, frequency) – If none, why:

## III. Admitting diagnosis (Axis I):

## IV. Functional assessment scores (DSM IV):

<table>
<thead>
<tr>
<th>GAF</th>
<th></th>
</tr>
</thead>
</table>

## V. No. of hospital days requested:

<table>
<thead>
<tr>
<th>Dates:</th>
<th>/ to /</th>
</tr>
</thead>
</table>

## VI. Aftercare Plan:

- Provider or Facility:
- Frequency:

## Signature (Attending MD):

<table>
<thead>
<tr>
<th>Date:</th>
<th>/ /</th>
</tr>
</thead>
</table>

Print Name:
B.49 Psychiatric Inpatient (Extended) Request Form

12365-A Riata Trace Parkway  TMHP CCIP  Phone: 800-213-8877
Austin, Texas 78727-6422  FAX: 512-514-4211

<table>
<thead>
<tr>
<th>I. Identifying information:</th>
<th>Medicaid #:</th>
<th>Date: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name:</td>
<td>First Name:</td>
<td>Middle initial:</td>
</tr>
<tr>
<td>Date of birth: / / Age: Sex:</td>
<td>Date of admission: / /</td>
<td></td>
</tr>
<tr>
<td>Facility name:</td>
<td>Provider Number:</td>
<td></td>
</tr>
<tr>
<td>Commitment Type: (if applicable)</td>
<td>Effective Date:</td>
<td></td>
</tr>
<tr>
<td>County: Judge:</td>
<td>Name of contact person:</td>
<td></td>
</tr>
</tbody>
</table>

IIA. Current status of primary symptoms that require continued acute hospital care:
(Include: 1. Date of most recent occurrence; 2. Frequency; 3. Duration; 4. Severity)

IIIA. Other relevant clinical/diagnostic information about patient from past 72 hours:
(Attach additional pages or documents, as necessary)

IIC. Current psychiatric medications (Include total daily dose)

IID. Discharge criteria:
1.
2.
3.

IIE. Describe treatment, contacts, plans (including outcome) with family, school, etc.

III. Current diagnosis (Axis I):

IV. Current functional assessment scores (DSM IV):
GAF [ ]

V. No. of hospital days requested: [ ] Dates: / / to / /
Projected discharge date (required): / /

VI. Aftercare plan:
Provider or Facility:
Frequency:
Signature (Attending MD): Date: / /
Print name:
B.50 Pulse Oximeter Form

Client Name: ____________________________________  Client Medicaid No: ________________________________

DME Provider Name and Address ____________________  Provider TPI No: ________________________________

________________________________________________  Provider Phone No: ________________________________

________________________________________________  Provider Fax No: ________________________________

HCPCS Code          Product Name and Model Number                                        Retail Price

_________________________           ________________________________________                        __________________________

New device provided for purchase   Yes_____No_____

**** Equipment designated for clinical use only is not considered appropriate for use in the home****

Oxygen dependent is defined as ongoing, regular need for use of supplemental oxygen for a significant portion of
the day to maintain oxygen saturation. This does not include: PRN use; when only used when sick; when only used
when suctioning; when desaturation occurs only when crying; when desaturation occurs only with seizure activity.

****The following information must be completed by the physician ****

Diagnosis and Basis for Medical Necessity of requested services: ______________________________________________

________________________________________________________________________________________________________

Dates of Service requested for Prior Authorization:   From ________________ To____________________

___ Client is ventilator and/or oxygen dependent
    Client is ventilator dependent ______________________________ hours per day
    Client is oxygen dependent ______________________________ hours per day

___ Client is weaning from oxygen and/or a ventilator

___ Anticipated length of monitor need:   Months____ 1-3 years _____ More than 3 years ____________________

___ Who will respond to monitor alarm?

___ Can the patient’s medical needs be meet with intermittent “spot check” of oxygen saturations? Yes_____ No ____

___ What is the medical basis for need of continuous monitoring?

________________________________________________________________________________________________________

___ Is the client receiving any nursing services such as PDN, Home Health Vists, MDCP, CBA, Private Insurance
    Please indicate services________________________Number of hours/vists__________________

Signature of prescribing physician____________________________Date _______________________

Printed or typed name of physician__________________________Phone No. _______________________

Physician License number______________________Physician Medicaid TPI _______________________

Must be submitted with a THSteps – CCP Prior Authorization Request Form
B.51 Request for Initial Outpatient Therapy (Form TP-1)

Form TP1 Request For Initial OUTPATIENT THERAPY

<table>
<thead>
<tr>
<th>Medicaid/CCP Case #</th>
<th>CSHCN Case #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name</td>
<td>DOB</td>
</tr>
<tr>
<td>Client’s Address (street, city, ZIP code, county)</td>
<td>Phone Number</td>
</tr>
</tbody>
</table>

HAS THE CHILD RECEIVED THERAPY IN THE LAST YEAR FROM THE PUBLIC SCHOOL SYSTEM?  ❑ Yes  ❑ No

Date of Initial Evaluation: PT_________ OT_________ SLP_________

COPY OF THE INITIAL EVALUATION MUST BE ATTACHED

ICD-9 code/DIAGNOSIS: ___________________________ Date of onset ______________________

CATEGORY OF THERAPY BEING REQUESTED:  * CSHCN only  # CCP only

❑ Developmental anomalies  ❑ Pre-surgery*  ❑ Post-surgery*  Date of surgery_________

❑ Cast Removal  Date Removed_________  ❑ Serial Casting  ❑ Acute Episode of Chronic Condition  ❑ New Condition

❑ Specialty Clinic  ❑ Home Program  ❑ ADL (activities of daily living)  ❑ Equipment Assessment  ❑ Equipment Training;

SPEECH for:  ❑ Craniofacial  ❑ Developmental Anomalies  ❑ New Condition  ❑ Post Cochlear Implant#

CHECK SERVICE REQUESTED, INDICATE THE DATE(S) OF SERVICE AND FREQUENCY PER WEEK OR MONTH:

(Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.)

___ PT service date(s) FROM________ TO _________ FREQUENCY per week _________ per month _____

___ OT service date(s) FROM________ TO _________ FREQUENCY per week _________ per month _____

___ SLP service date(s) FROM________ TO _________ FREQUENCY per week _________ per month _____

Procedure code(s) for therapy services ____________________________

Print or Type Name

Physician ___________________________ Physician’s Signature ___________________________ Date Signed _________

Therapist’s (PT) ___________________________ Therapist’s Signature ___________________________ Date Signed _________

Therapist’s (OT) ___________________________ Therapist’s Signature ___________________________ Date Signed _________

Therapist’s (SLP) ___________________________ Therapist’s Signature ___________________________ Date Signed _________

PROVIDER CONTACT: ___________________________ PHONE # ( ) _______ FAX # ( ) _______

PROVIDER’S NAME: ____________________________

BILLING ADDRESS: ____________________________

MEDICAID PROVIDER # ___________________________ CSHCN PROVIDER # ___________________________

FOR OFFICE USE ONLY:  Medicaid  ❑ Yes  ❑ No  HMO  ❑ Yes  ❑ No  Restrictions:

PAN # _______________ Valid _______________ To _______________ FORM TP1
Form TP-2 Request For EXTENSION of OUTPATIENT THERAPY

CCP - Texas Medicaid & Healthcare Partnership
PO Box 200735
Austin, TX 78720-0735
1-800-846-7470
C CP fax: 1-512-514-4212

TMHP-CSHCN
Children with Special Health Care Needs Services Program
PO Box 200855
Austin, TX 78720-0855
1-800-568-2413 or 1-512-514-3000
fax: 1-512-514-4222

Medicaid/CCP Case #

CSHCN Case #

Client Name

DOB

Client’s Address (street, city, ZIP code, county)

Phone Number

HAS THE CHILD RECEIVED THERAPY IN THE LAST YEAR FROM THE PUBLIC SCHOOL SYSTEM? ❑ Yes ❑ No

Date of Initial Evaluation: PT_________ OT_________ SLP_________

COPY OF THE INITIAL EVALUATION MUST BE ATTACHED

ICD-9 code/DIAGNOSIS: __________________________ Date of onset __________________________

CATEGORY OF THERAPY BEING REQUESTED: * CSHCN only # CCP only

PT/OT for: ❑ Developmental anomalies ❑ Pre-surgery* ❑ Post-surgery* Date of surgery _______________

❑ Cast Removal Date Removed ______________ ❑ Serial Casting ❑ Acute Episode of Chronic Condition ❑ New Condition

❑ Specialty Clinic ❑ Home Program ❑ ADL (activities of daily living) ❑ Equipment Assessment ❑ Equipment Training;

SPEECH for: ❑ Craniofacial ❑ Developmental Anomalies ❑ New Condition ❑ Post Cochlear Implant #

CHECK SERVICE REQUESTED, INDICATE THE DATE(S) OF SERVICE AND FREQUENCY PER WEEK OR MONTH:
(Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.)

___ PT service date(s) FROM ___________ TO ___________ FREQUENCY per week ________ per month ________

___ OT service date(s) FROM ___________ TO ___________ FREQUENCY per week ________ per month ________

___ SLP service date(s) FROM ___________ TO ___________ FREQUENCY per week ________ per month ________

Procedure code(s) for therapy services __________________________

Print or Type Name

Physician __________________________ Physician’s Signature __________________________ Date Signed ____________

Therapist’s (PT) __________________________ Therapist’s Signature __________________________ Date Signed ____________

Therapist’s (OT) __________________________ Therapist’s Signature __________________________ Date Signed ____________

Therapist’s (SLP) __________________________ Therapist’s Signature __________________________ Date Signed ____________

PROVIDER CONTACT: __________________________ PHONE # (____) __ FAX # (____) __________

PROVIDER’S NAME: __________________________

BILLING ADDRESS: __________________________

MEDICAID PROVIDER # __________________________ CSHCN PROVIDER # __________________________

FOR OFFICE USE ONLY: Medicaid ❑ Yes ❑ No HMO ❑ Yes ❑ No Restrictions:

TPYEXTCCP.TP2 – 6/10/97 FORMTP-2
PAN # ______________________ valid _______ to ________

Medicaid/CCP case # ______________________

CSHCN Case # ______________________

Client Name ______________________

DOB ______________________

CURRENT FUNCTIONAL STATUS:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

NEW TREATMENT GOALS: ______________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

PRIOR DATES OF SERVICE from ______________________ to ______________________

PRIOR FUNCTIONAL STATUS:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

PRIOR TREATMENT GOALS: ______________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

PRIOR TREATMENT PROVIDED: ____________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
### B.53 Request for Extended Outpatient Psychotherapy/Counseling Form

<table>
<thead>
<tr>
<th>1. Identifying information:</th>
<th>Medicaid #:</th>
<th>Date: / /</th>
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</thead>
<tbody>
<tr>
<td>Last name:</td>
<td>First name:</td>
<td>Middle initial:</td>
</tr>
<tr>
<td>Date of birth: / /</td>
<td>Age:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Performing Provider:</td>
<td>Medicaid Provider number (TPI):</td>
<td></td>
</tr>
<tr>
<td>Current living arrangements: ( ) with family ( ) group/foster home ( ) other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Current DSM IV diagnosis (list all appropriate codes):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I diagnosis:</td>
</tr>
<tr>
<td>Current substance abuse? ( ) none ( ) alcohol ( ) drugs ( ) alcohol and drugs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Recent primary symptoms that require additional therapy/counseling:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include date of most recent occurrence, frequency, duration, and severity:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric inpatient treatment ( ) yes ( ) no</td>
</tr>
<tr>
<td>Prior substance abuse? ( ) none ( ) alcohol ( ) drugs ( ) alcohol and drugs</td>
</tr>
<tr>
<td>Significant medical disorders:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Current psychiatric medications (include dose and frequency):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6. Treatment plan for extension:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurable short term goals, specific therapeutic interventions utilized and measurable expected outcome(s) of therapy:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Number of additional sessions requested (limit 10 per request):</th>
</tr>
</thead>
<tbody>
<tr>
<td>List specific procedure codes requested:</td>
</tr>
<tr>
<td>How many of each type?</td>
</tr>
<tr>
<td>Dates from (start of extension visits): / /</td>
</tr>
<tr>
<td>Provider signature:</td>
</tr>
<tr>
<td>Print name:</td>
</tr>
</tbody>
</table>
B.54  Sample Letter - XUB Computer Billing Service Inc.

XUB Computer Billing Service, Inc.
4040 Main Street
Anytown, USA 11111

Dear Sir:

This letter authorizes the XUB Computer Billing Service, Inc. to use my signature and to attest on my behalf to the requirements authorized in the following paragraphs, when submitting Medicaid claims on my behalf.

This is also to certify that information appearing on billings submitted by me for the Texas Medical Assistance Program is and will be true, accurate, and complete. I understand that payment of any Texas Medical Assistance Program claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. These certifications are made in accordance with requirements found at 42 Code Federal Regulations 455.18 and 455.19.

I also certify that the items billed to the Texas Medical Assistance Program are and will be for services that have been and will be personally provided by me or under my personal direction, and in cases of physician services, the services, supplies, or other items billed have been and will be medically necessary for the diagnosis or treatment of the condition of the patients, and are provided without regard to race, color, sex, national origin, age, or handicap.

Additionally, I agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the Texas Medical Assistance Program. I also agree to furnish them at no cost and provide access to information regarding any payments claimed for providing such services as the State Agency, Attorney General’s Office, and Department of Health and Human Services (HHS) Office may request for five years from date of service (6 years for freestanding rural health clinic; 10 years for hospital-based rural health clinic), or until any dispute is settled, whichever occurs first.

I agree to accept the amounts paid by the Medicaid Program as full payment for the services rendered for which a Medicaid benefit is provided under the Texas Medical Assistance Program.

This letter, to be retained in your files, bears my true and original signature:

_____________________________________________________________
Provider Signature, Medicaid TPI
B.55 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen, Instructions

**Note:** Form G-1C, Maternal Serum Prenatal Triple Screen, is provided for the provider’s convenience. Previously it was part of the G-1B form. It is not a THSteps form.

For information on Triple Screens, call: 1-800-687-4363 or 1-888-963-7111 x7138 or Fax: (512) 458-7139.
For mailing and specimen packaging information, visit DSHS Laboratory Services Section’s web page at http://www.dshs.state.tx.us/lab/.

The specimen submission form must accompany each specimen. The patient’s name listed on the specimen must match the patient’s name listed on the form. If the Date of Collection field is not completed, the specimen will be rejected.

**Section 1. SUBMITTER INFORMATION**
All submitter information is required.

Submitter/TPI number, Submitter name and Address:
Indicate the submitter’s name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Laboratory Services Section.

The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. To obtain a TPI number, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 458-7578, or fax (512) 458-7533.

Contact Information: Indicate the telephone number and name of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen. The fax number should indicate the number of the fax machine where the report should be sent.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

**Section 2. PATIENT INFORMATION**
Complete all patient information including last name, first name, middle initial, date of birth, medical records number, race/ethnicity, address, ICD diagnosis code, city, state, zip code, and country of origin.

NOTE: The patient’s name listed on the specimen must match the patient’s name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**).
You may use a pre-printed patient label.

ICD diagnosis code: Indicate the diagnosis code that would help in processing, identification, and billing of this specimen.

**Section 3. TRIPLE SCREEN REQUEST & PATIENT INFORMATION**
In order to interpret this test, all patient information in this section of this form must be provided. Without the date of collection, accurate gestational age, maternal weight, maternal date of birth, maternal race, and information about maternal diabetic status, a complete assessment cannot be made. The time and date the specimen is removed from freezer must be provided to determine specimen acceptability.

**Section 4. PHYSICIAN INFORMATION**

Physician’s name and UPIN: Give the name of the physician and their unique physician ID number (UPIN), if applicable. This information is required to bill Medicare.

**Section 5. PAYOR SOURCE**

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided.

Indicate the party that will receive the bill.

Medicaid or Medicare:
- Mark the appropriate box, write in the Medicaid or Medicare number, and
- Supply a copy of the Medicaid or Medicare card.

Private Insurance:
- Mark the appropriate box,
- Supply a copy of the front and back of the insurance card, &
- Complete all fields on the form that have an asterisk (*).

DSHS Program:
- Do NOT check a DSHS program as a Payor Source if the patient has Medicaid or Medicare.
- If you are contracting and/or enrolled with a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section’s Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/.
- If there is no other Payor Source for the patient and the patient meets the program’s eligibility criteria, check the appropriate DSHS program.

HMO / Managed care / Insurance company: Print the name, address, city, state, and zip code of the insurance company to be billed.

Responsible party: Print the name of the responsible party, the insurance ID number, insurance company’s phone number, group name, and group number.

Signature and Date: Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

For specific test instructions and information about tube types, see the Laboratory Services Section Manual of Reference Services on our web site at http://www.dshs.state.tx.us/lab/.
B.56 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen

**Note:** Form G-1C, Maternal Serum Prenatal Triple Screen, is provided for the provider’s convenience. Previously it was part of the G-1B form. It is not a THSteps form.

---

### Section 1. SUBMITTER INFORMATION

<table>
<thead>
<tr>
<th>Submitter/TPI Number</th>
<th>Submitter Name</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Contact</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fax</th>
<th>Clinic Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### Section 2. PATIENT INFORMATION - (**REQUIRED Fields**)

**Note:** Patient name on specimen is **REQUIRED** and **MUST** match name on form.

<table>
<thead>
<tr>
<th>Last Name**</th>
<th>First Name **</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yy)**</th>
<th>Medical Records Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity:</th>
<th>Asian</th>
<th>Chinese</th>
<th>Hispanic</th>
<th>African</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Patient Address**</th>
<th>ICD Diagnosis Code</th>
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<table>
<thead>
<tr>
<th>City**</th>
<th>State</th>
<th>Zip Code</th>
<th>Country of Origin</th>
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### Section 3. TRIPLE SCREEN REQUEST & PATIENT INFORMATION

**For Laboratory Use Only**

<table>
<thead>
<tr>
<th>O.B. History</th>
<th>P</th>
<th>AB</th>
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<tbody>
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</table>

**Multiple fetuses?**

Yes [ ]  No [ ]

Specify number of fetuses: __________

**On insulin prior to pregnancy (IDDM)**

Yes [ ]  No [ ]

Specify: __________

**Maternal medication**

Yes [ ]  No [ ]

Specify: __________

**Repeat specimen?**

Yes [ ]  No [ ]

If yes, indicate reason: __________

---

**Gestational Age (Select one calculation method)**

<table>
<thead>
<tr>
<th>Date of LMP (mm/dd/yy)</th>
<th>Ultrasound dating weeks on (mm/dd/yy)</th>
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</thead>
<tbody>
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<thead>
<tr>
<th>If sono by 1/10 of week weeks on (mm/dd/yy)</th>
<th>Physical exam weeks on (mm/dd/yy)</th>
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**CURRENT WEIGHT**

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<th>DATE OF COLLECTION</th>
<th>TIME OF COLLECTION</th>
<th>COLLECTED BY</th>
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</thead>
<tbody>
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</table>

**Time and Date of Removal from Freezer prior to shipping (REQUIRED)**

|                    |                    |                |
|                    |                    |                |

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**NOTES:** Please see the form’s instructions for details on how to complete this form. Details of test and specimen requirements can be found in the Laboratory Services Section’s Manual of Reference Services. Visit our web site at [http://www.dshs.state.tx.us/lab/](http://www.dshs.state.tx.us/lab/).
Instrucciones para el formulario de remisión de muestras G-1C

Examen sistemático triple prenatal del suero materno

Para información sobre los exámenes sistemáticos triples, llame al: 1-800-687-4363 ó 1-888-963-7111 x7138
ó mande un fax al: (512) 458-7139.

Para información sobre el envío y el empaquetamiento de las muestras, visite nuestra página del Internet de la Sección de Servicios de Laboratorio del DSHS: http://www.dshs.state.tx.us/lab/ (en inglés).

El formulario de remisión de muestras tiene que acompañar a cada muestra.

El nombre del paciente que aparece en la muestra tiene que concordar con el nombre del paciente que aparece en el formulario.

Si el campo "Fecha de recogida" no está llenado, se rechazará la muestra.

### Sección 1. INFORMACIÓN SOBRE EL REMITENTE

**Número de remitente / Número TPI, Nombre y dirección del remitente:** Indique el nombre, dirección, ciudad, estado, y código postal del remitente. Escriba claramente en letra de molde, utilice una etiqueta impresa de antemano, o utilice una fotocopia de un formulario original proporcionado por la Sección de Servicios de Laboratorio.

El número de remitente es un número único que la Sección de Servicios de Laboratorio del Texas Department of State Health Services [Departamento Estatal de Servicios de Salud de Texas, DSHS, por sus siglas en inglés] asigna a cada uno de nuestros remitentes. Para obtener un número TPI, comuníquese con Texas Medicaid and Healthcare Partnership, (TMHP, por sus siglas en inglés) al 1-800-925-9126.

Para pedir un número de remitente de la Sección de Servicios de Laboratorio del DSHS, un formulario original, o para cambiar la información del remitente, llame al (888) 963-7111 x7538 ó mande un fax al (512) 458-7533.

**Información localizadora:** Indique el número de teléfono y el nombre de la persona apropia la en el centro remitente con quien el laboratorio puede comunicarse si es que se necesita más información sobre la muestra. El número de fax debe indicar el número de fax adónde se debe enviar el informe.

**Código de la clínica:** Favor de proporcionarlo, si se aplica. Éste es un código que el remitente proporciona si tiene una dirección postal principal y oficinas satélites. El código le ayuda al remitente a identificar cuál de los satélites remite la muestra y dónde es que pertenece el informe del laboratorio.

### Sección 2. INFORMACIÓN SOBRE EL PACIENTE

Llene toda la información sobre el paciente inclusive el apellido, primer nombre, inicial del segundo nombre, fecha de nacimiento, número del expediente médico, raza / etnicidad, dirección, código diagnóstico ICD, ciudad, estado, código postal, y país de origen.

**NOTE:** El nombre del paciente que aparece en el formulario tiene que concordar con el nombre que aparece en el formulario.

La información que es requerida para pasarle la factura a Medicare, Medicaid, o al seguro privado ha sido marcada con dos asteriscos (**). Usted puede utilizar una etiqueta de paciente impresa de antemano.

**El código diagnóstico ICD:** Indique el código diagnóstico que ayudaría en el procesamiento, la identificación, y la facturación de esta muestra.

### Sección 3. EXAMEN SISTEMÁTICO TRIPLE

**E INFORMACIÓN SOBRE EL PACIENTE**

Para interpretar este examen, toda la información en esta sección de este formulario deberá ser proporcionada. Sin la fecha de recogida, la edad gestacional precisa, el peso materno, la fecha de nacimiento de la madre, la raza de la madre, e información sobre el estado diabético de la madre, no se puede llevar a cabo una evaluación completa. Tiene que proporcionarse la hora y la fecha cuando se saca la muestra del congelador para determinar la aceptabilidad de la muestra.

### Sección 4. INFORMACIÓN SOBRE EL MÉDICO

**Nombre del médico y UPIN:** Proporcione el nombre del médico y su número único de identificación para médicos (UPIN, por sus siglas en inglés), si se aplica. Se requiere esta información para pasarle la factura a Medicare.

### Sección 5. FUENTE DE PAGADOR SE LE PASARÁ LA FACTURA AL REMITENTE si no se proporciona la información requerida para la facturación.

Indique quién recibirá la factura.

**Medicaid o Medicare:**
- Marque la casilla apropiada, escriba el número de Medicaid o Medicare, y
- Provea una copia de la tarjeta de Medicaid o Medicare.

**Seguro privado:**
- Marque la casilla apropiada,
- Provea una copia de los dos lados de la tarjeta de seguro, y
- Llene todos los campos del formulario que tienen un asterisco (*).

**Programa del DSHS:**
- NO marque un programa del DSHS como la fuente de pagador si el paciente tiene Medicaid o Medicare.
- Si usted está contratando y / o está inscrito(a) en un programa del DSHS para proporcionar servicios que requieren análisis de laboratorio, indique qué programa es.

Para descripciones de los programas, vea el Manual de

- Si no hay ninguna otra fuente de pagador para el paciente y el paciente reúne los criterios de elegibilidad para el programa, marque el programa apropiado del DSHS.

**HMO / Cuidado manejado / Compañía de seguros:** Escriba en letra de molde el nombre, la dirección, la ciudad, el estado, y el código postal de la compañía de seguros a la cual se pasará la factura.

**Firmante responsable:** Escriba en letra de molde el nombre del firmante responsable, el número de identificación del seguro, el número de teléfono de la compañía de seguros, el nombre del grupo, y el número del grupo.

**Firma y Fecha:** Pida que la persona responsable firme y ponga la fecha para autorizar la revelación de su información, si es que el DSHS le mandará la factura a su seguro o HMO.

Para indicaciones específicas para las pruebas e información sobre los tipos de tubos, vea el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en nuestra página del Internet: http://www.dshs.state.tx.us/lab/.
B.58 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen (Spanish)

---

**Section 1. INFORMACIÓN SOBRE EL REMITENTE**

Nombre del remitente / Número TPI Nombre del remitente

Dirección

Ciudad Estado Código Postal

Número de teléfono Contacto

Fax Código de la clínica

**Section 2. INFORMACIÓN SOBRE EL PACIENTE** - (**Campos REQUERIDOS)**

Apellidos** Primer nombre** Inicial del 2º nombre

Fecha de nacimiento (mm/dd/año)** Número del expediente médico

Raza / Etnicidad

Dirección del paciente** Código diagnóstico ICD

Ciudad** Estado** Código Postal

**Section 3. SOLICITUD PARA EL EXAMEN SISTEMÁTICO TRIPLE E INFORMACIÓN SOBRE EL PACIENTE**

(Se requiere toda la información para llevar a cabo el examen)

Historial obstétrico G ______________ P ______________ AB ______________

¿Fetos múltiples? Sí No

¿Usó insulina antes del embarazo? Sí No

Medicamentos de la madre Sí No

¿Muestra repetida? Sí No

Edad gestacional (Seleccione un método de cálculo.)

Historia del último periodo menstrual

Fechas de ultrasonido

Examen físico

Revisión del congelador

PESO ACTUAL FECHA DE RECOGIDA HORA DE RECOGIDA RECOGIDO POR QUIEN Hora y fecha cuando se sacó del congelador antes del envío

---

NOTAS: Sirvase ver las instrucciones para el formulario para detalles en cómo llenar este formulario. Los detalles sobre los requisitos para los análisis y las muestras se pueden encontrar dentro del Manual de servicios de referencia de la Sección de Servicios de Laboratorio. Visite nuestro sitio en el Internet: http://www.dshs.state.tx.us/lab/
**B.59 Statement for INITIAL Wound Therapy System In-Home Use (2 Pages)**

| Patient Name: _______________________________ | Birthdate: _______________________________________________ |
| Medicaid Number: ____________________________ | Diagnosis: ______________________________________________ |
| Physician Name: _____________________________ | Physician Phone Number: __________________________________ |
| Physician Provider/License Number: _______________ | Home Health Agency Name & Provider Number: _________________ |

**INDICATORS FOR INITIAL WOUND THERAPY**

Must be completed by the physician familiar with the client and prescribing the wound care system. Answer “Yes” or “No” for each question and mark any answers which apply.

1. The patient has had one or more of the following: **YES** **NO**
   - ____ Stage III or Stage IV pressure ulcer
   - ____ diabetic ulcer
   - ____ pre-operative myocutaneous flap or graft
   - ____ chronic open wound
   - ____ recent (within 14 days) myocutaneous flap or graft
   - ____ venous stasis ulcer

2. The patient’s history reflects one or more of the following: **YES** **NO**
   - ____ previous failed wound care interventions, how long ago __________, how was it resolved ________________
   - ____ severe coexisting chronic illness
   - ____ frequent reoccurrence of advanced pressure ulcers related to severely limited mobility
   - ____ wound care therapy was initiated in the hospital or SNF, if “Yes”, supply:
     - Admission date: ________________
     - Admitting diagnosis: _________________
     - Discharge date: ________________

3. The patient uses a pressure-reducing surface: **YES** **NO**
   - ____ nonpowered mattress overlay
   - ____ powered mattress replacements
   - ____ nonpowered mattress replacement
   - ____ powered bed system
   - ____ powered mattress overlay
   - ____ air fluidized bed

   **NOTE:** If “NO,” why not? ___________________________________________________________________________

4. The patient has an albumin greater than 3 mg/dl. **YES** **NO**
   - **Date of last albumin (within the past 30 days):** ________________
   - **Result:** ________________

   **NOTE:** If the patient has an albumin level less than 3 mg/dl, please list the albumin level and describe the type of nutritional treatment which the patient is receiving: __________________________________________________________

5. The patient has diabetes mellitus **YES** **NO**
   - **Hemoglobin A1c level:** ________________
   - **Date Hemoglobin A1c drawn (within past 30 days):** ________________

6. The patient’s wound is free of necrotic tissue. **YES** **NO**

   **NOTE:** If the wound has recently been debrided, identify the type and date of debridement:
   - ____ surgical Date: ________________
   - ____ chemical Date: ________________
   - ____ physical Date: ________________
   - ____ autolytic Date: ________________

7. The patient’s wound is free of infection. **YES** **NO**

   **NOTE:** If the wound is infected, identify the wound treatment, include dosage, frequency, route and duration of any Medications: __________________________________________________________________________________________

8. The patient’s overall health status will allow wound healing. **YES** **NO**

   **NOTE:** Describe all medical conditions which might affect wound healing, address incontinence if pertinent, and what is being done to decrease contamination of the wound: __________________________________________________________________________________________

9. Name of family member/friend/caregiver who agrees to be available to assist patient: ________________________________________________________________

| Physician Signature: _______________________________ | Date: ______________________________ |

---
## CONTRAINDICATORS TO INITIAL WOUND THERAPY

Must be completed by the physician familiar with the client and prescribing the wound care system or the registered nurse (RN). Check any that apply.

Does the patient have any of the following conditions: YES NO

- _____ fistulas to the body
- _____ wound ischemia
- _____ gangrene
- _____ skin cancer in the margins
- _____ osteomyelitis (unless being treated - describe below)
- _____ presence of necrotic tissue, including bone
- _____ less than six months to live

## INITIAL WOUND PROFILE

Must be completed by the physician familiar with the client and prescribing the wound care system or the RN. **NOTE:** Use additional paper if more than two wounds are currently being treated.

### Wound #1:

<table>
<thead>
<tr>
<th>Type of wound:</th>
<th>Pressure ulcer</th>
<th>Diabetic ulcer</th>
<th>Pre-operative myocutaneous flap or graft</th>
<th>Chronic open wound</th>
<th>Recent (within 14 days) myocutaneous flap or graft</th>
<th>Venous stasis ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
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<tr>
<td>Stage:</td>
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<tr>
<td>Age of wound:</td>
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<tr>
<td>Date of surgery (if flap or graft):</td>
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<tr>
<td>Type of debridement and date:</td>
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<tr>
<td>Wound color:</td>
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<tr>
<td>L x W x D:</td>
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<tr>
<td>Odor:</td>
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<tr>
<td>Drainage:</td>
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<tr>
<td>Tunneling (depth and position):</td>
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<tr>
<td>Undermining (depth and position):</td>
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<tr>
<td>List all previous wound interventions: (use additional space if necessary):</td>
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### Wound #2:

<table>
<thead>
<tr>
<th>Type of wound:</th>
<th>Pressure ulcer</th>
<th>Diabetic ulcer</th>
<th>Pre-operative myocutaneous flap or graft</th>
<th>Chronic open wound</th>
<th>Recent (within 14 days) myocutaneous flap or graft</th>
<th>Venous stasis ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
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<td>Stage:</td>
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<tr>
<td>Age of wound:</td>
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<tr>
<td>Date of surgery (if flap or graft):</td>
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<tr>
<td>Type of debridement and date:</td>
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<tr>
<td>Wound color:</td>
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<td>L x W x D:</td>
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<td>Odor:</td>
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<td>Drainage:</td>
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<tr>
<td>Tunneling (depth and position):</td>
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<tr>
<td>Undermining (depth and position):</td>
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</tr>
<tr>
<td>List all previous wound interventions: (use additional space if necessary):</td>
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</tbody>
</table>

**Physician Signature:** ________________________  **Date:** ________________________

**RN Signature:** ________________________  **Date:** ________________________
B.60  Statement for RECERTIFICATION of Wound Therapy System In-Home Use

Patient Name: _______________________________  Birthdate: ____________________________________________________________________________
Medicaid Number: ____________________________  Diagnosis: __________________________________________________________________________
Physician Name: _____________________________  Physician Phone Number: __________________________________
Physician Provider/License Number: _______________  Home Health Agency Name & Provider Number: _________________

INDICATORS FOR CONTINUATION OF TREATMENT
Must be completed by the physician familiar with the client and prescribing the wound care system. Answer “Yes” or “No” for each question and any answers which apply.

1. Was the initial medical necessity justified by one of the following?  YES    NO
    _____ Stage III or Stage IV pressure ulcer  _____ diabetic ulcer
    _____ pre-operative myocutaneous flap or graft  _____ chronic open wound
    _____ recent (within 14 days) myocutaneous flap or graft  _____ venous stasis ulcer

2. Is the wound showing progress?  YES    NO
    _____ 30 days or longer since myocutaneous flap or graft  _____ wound healed, no depth
    _____ 30 days with no demonstrated improvement  _____ wound healing with improvement

Location: _________________________________  Stage: _______________  Age of wound: ____________________
Wound color: _______________  L x W x D: _______________  Odor: _______________  Drainage: _______________
Tunneling (depth and position): _______________________  Undermining (depth and position): __________________
Wound description (ie. formation of granulation and date and type of debridement done in last 30 days):________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________

NOTE: Include above information for each wound if more than one.

3. The patient continues to use a pressure-reducing surface: YES    NO
    NOTE: If “NO,” why not? __________________________________________________________________________

4. Name of family member/friend/caregiver who continues to agree to assist patient: ________________________________

Contraindicators to Continuation of Treatment
(Check any that apply)

1. Does the patient have any of the following conditions  YES    NO
    _____ fistulas to the body  _____ osteomyelitis (unless being treated – describe below)
    _____ wound is ischemic  _____ presence of necrotic tissue, including bone
    _____ gangrene  _____ skin cancer in the margins  _____ less than six months to live
    _____ no demonstrable improvement in wound over past 30 days

___________________________________________________________________________________________________
___________________________________________________________________________________________________

Physician Signature: ____________________________________________________________________________  Date: _______________
B.61 Sterilization Consent Form Instructions

Per federal regulation 42 CFR 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Ensure all required fields are completed for timely processing.

Fax the Sterilization Consent Form five business days before to submitting the associated claim(s,) to expedite the processing of the Sterilization Consent Form and associated claim(s). Fax to 1-512-514-4229.

Sterilization Consent Form Instructions

Fax fully completed Sterilization Consent Forms to TMHP at 1-512-514-4229. Each consent should be accompanied by a separate cover sheet identifying the provider submitting the form and should include the provider’s TPI, mailing address, fax number, and telephone number. Claims and appeals are not accepted by fax. Only send Family Planning sterilization correspondence to this fax number.

Note: Hysterectomy Consent forms should be faxed to 1-512-514-4218.

Clients must be at least 21 years of age when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

Exception: Premature delivery—There must be at least 30 days between the date of consent and the client’s expected date of delivery. Cases of Emergency Abdominal Surgery—There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form published in this manual. Completion of all sections is required to validate the consent form, with only two exceptions:

Exception: Race and ethnicity designation is always optional. The Interpreter’s Statement is not required as long as the consent form is written in the client’s language, or the person obtaining the consent speaks the client’s language. However, if this section is only partially completed, the consent will not be accepted as a valid consent.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation.

Required Fields

Any illegible field will result in a denial of the submitted consent form.

Consent to Sterilization

- Client Medicaid/Family Planning Number—For Title XIX (Medicaid) clients, use the client’s Medicaid number. For non-Medicaid clients, use the client’s assigned Family Planning number. If a Family Planning number is not available, write “Title V” or “Title XX” depending on the funding source.
- Client Name (first and last names required).
- Client’s Address (street address, city, state, and zip code required).
- Name of Doctor or Clinic.
- Name of the Sterilization Procedure.
- Day of Client’s Birth date.
- Month of Client’s Birth date.
- Year of Client’s Birth date.
- Client’s Name (first and last names required).
- Name of Doctor or Clinic.
- Name of the Sterilization Procedure.
- Client’s Signature.
- Time of Day, Month, Day, and Year Client Signed the Consent to Sterilization—Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.

Interpreter’s Statement (If applicable)

- Interpreter’s Statement
- Name of Language Used by Interpreter
- Interpreter’s Signature
- Day, Month, and Year of Interpreter’s Signature

Statement of Person Obtaining Consent

- Client’s Name (first and last names required).
- Name of the Sterilization Operation.
- Signature of Person Obtaining Consent—The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, not a rubber stamp.
- Day, Month, and Year the Person Obtaining Consent Signed the Consent form (must be the same date as the client’s signature date).
- Facility of the Person Obtaining Consent or the Clinic/Office where the Client Received the Sterilization Information.
- Address of Facility of the Person Obtaining Consent or the Clinic/Office where the Client Received the Sterilization Information (street address and city required).

Note: Including the nine-digit provider identification number will expedite the processing of the consent form.

Physician’s Statement

- Client’s Name (first and last names required).
- Time of Day, Month, Day, and Year Sterilization Procedure was Performed—Must be at least 30 days and no more than 180 days from the date of the client consent except in cases of premature delivery or emergency abdominal surgery.
- Name of the Sterilization Operation.
- Expected Date of Delivery (EDD)—Required when there are less than 30 days between the date of the client consent and date of surgery. Client’s signature date must be 30 days prior to EDD.
- Circumstances of Emergency Surgery—Operative reports detailing the need for emergency abdominal surgery are required.
- Physician’s Signature—Stamped or computer-generated signatures are not acceptable.
- Day, Month, and Year the Physician Signed the Physician Statement—This date must be on or after the date of surgery.

Funding Source

The provider must indicate if the client is a non-Title XIX client. The provider can do this by indicating on the consent that the client is a Title V, X, or XX client, or by circling the Non-Title XIX box in the lower right corner of the consent form. Failure to identify the client as a Title V, X, or XX will result in the consent being processed as a Title XIX. If the client’s Medicaid number is not on the form and cannot be determined, the consent will be denied.
B.62 Sterilization Consent Form (English)

NOTICE:
YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS

CLIENT MEDICAID/FAMILY PLANNING NUMBER

CONSENT TO STERILIZATION

I, ________________________________________________, hereby consent of my own free will to be sterilized by __________________________ by a method called ____________________________________.

My consent expires 180 days from the date of my signature below.

Before, ___________________ (name of individual) signed this consent form, I explained to him/her the nature of the sterilization operation ____________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of Person Obtaining Consent: __________________________________________________________

Date: __________________________________________ (month, day, year)

Facility: ____________________________________________

Address: ____________________________________________

PHYSICIAN’S STATEMENT

Shortly before I performed a sterilization operation upon _______________________________, I explained to him/her the nature of the sterilization operation ____________________________, the type of operation, the fact that it is intended to be a final and irreversible procedure, and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in cases of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual’s signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual’s signature on this consent form because of the following circumstances (check applicable box and fill in information requested).

Signature of Physician: __________________________ Date: __________

Premature delivery-Individual’s expected date of delivery: ________________

Emergency abdominal surgery-Describe circumstances: ________________

FUNDING SOURCE (Office Use Only)

Please circle one

Title XIX

Non-Title XIX
B.63 Sterilization Consent Form (Spanish)

**AVISO:** SI EN CUALQUIER MOMENTO USTED DECIDE NO DEJARSE ESTERILIZAR, ESTA DECISION NO RESULTARA EN LA RETENCION NI EL RETIRO DE BENEFICIOS OFRECIDOS POR NINGUN PROGRAMA O PROYECTO QUE RECIBA FONDOS FEDERALES.

CLIENT MEDICAD/FAMILY PLANNING NUMBER

CONSENTAMIENTO PARA LA ESTERILIZACION

Yo, ___________ (nombre completo de la persona que se va a operar) con residencia en __________ (dirección), he solicitado y he recibo información sobre la Esterilización de ___________ (nombre del doctor o de la clínica) Cuando solicité la información, me dijeron desde un principio que yo mismo haría la decisión sobre esterilizarme o no. Si decidio no esterilizarme, esta decisión no afectará mi derecho a atención y tratamiento en el futuro. Tampoco resultará en la pérdida de ayuda y beneficios de programas que reciben fondos federales, como, por ejemplo, T.A.N.F. y Medicaid, que recibo ahora o que pueda calificar para recibir después.

**COMPRENDO QUE LA ESTERILIZACION SE CONSIDERA PERMANENTE E IRREVERSIBLE. HE DECIDIDO QUE NO DESEO CONCEibir, DAR A LUZ, NI ENGENDRAR HIJOS.**

Me describieron los métodos temporales de control de la natalidad que se pueden emplear y que me pueden ofrecer, que me permitirían en el futuro encargar o engendrar un hijo. He rechazado esas alternativas y he elegido ser esterilizado(a).

Comprendo que mi esterilización será por medio de una operación que se llama ___________. Me han explicado las molestias y riesgos de la operación, lo mismo que los beneficios. Contestaron a mi satisfacción todas las preguntas que tuve. Comprendo que la operación no se hará hasta 30 días después de firmar yo este consentimiento. Contestaron que puedo cambiar de opinión cualquier momento y que mi decisión en cualquier momento de no esterilizarme no resultará en la retención de ningunos beneficios o servicios de programas que reciben fondos federales. Tengo al menos 21 años de edad. Nací el (día) ___________ (mes) ___________ (año) ______.

Yo, ___________ (nombre), con esto como voluntariamente a la esterilización practicada por ____________________________ empleando el método que se llama ___________. Este consentimiento expira a los 180 días de la fecha de mi firma al final de este documento. También autorizo que se den copias de este consentimiento y de otros documentos médicos relativos a mi operación a:

Representantes del Departamento de Salud y Servicios Humanos, o Empleados de programas o proyectos que reciben fondos de ese Departamento. Sólo para determinar si las leyes federales fueron observadas.

He recibido una copia de este consentimiento.

Firma: ______________________________________
Fecha: __________________________ (hora y mes, día, año)

**AVISO:** Se le pide a usted que ofrezca la siguiente información, pero no es requisito.

**DESIGNACION ETNICA O DE RAZA**

Negro (no de origen Hispano) ___________

Origen Hispano ___________

Asiático o de las Islas del Pacífico ___________

Indio Americano o Indigena de Alaska ___________

Blanco (no de origen Hispano) ___________

**INTERPRETER’S STATEMENT** (all blanks must be completed if an interpreter is used).

If an interpreter is provided to assist the individual to be sterilized, I have translated the information and advice presented orally to the individual to be sterilized by the individual obtaining this consent. I have also read him/her the consent form in __________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Signature of the interpreter: ____________________________ Date: __________________________

**STATEMENT OF PERSON OBTAINING CONSENT**

Before, __________________ (name of individual) signed this consent form, I explained to him/her the nature of the sterilization operation ______________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of Person Obtaining Consent: ____________________________ Date: __________________________

**PHYSICIAN’S STATEMENT**

Shortly before I performed a sterilization operation upon __________________ (name of individual to be sterilized), on __________________ (time and date of sterilization operation), I explained to him/her the nature of the sterilization operation ________________________, the fact that it is intended to be a final and irreversible procedure, and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in cases of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual’s signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual’s signature on this consent form because of the following circumstances (check applicable box and fill in information requested).

Pregnancy-Premature delivery-Individual’s expected date of delivery: __________________________

Signature of Physician: ____________________________ Date: __________________________

**FUNDING SOURCE (Office Use Only)**

Please circle one

Title XIX

Non-Title XIX
### B.64 Synagis® (Palivizumab) Prescription Form

**TEXAS MEDICAID VENDOR DRUG PROGRAM**
**SYNAGIS® (PALIVIZUMAB) PRESCRIPTION FORM**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Texas Medicaid Recipient Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>Gender: ☐ Male ☐ Female</td>
</tr>
<tr>
<td>Address (Street)</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State ZIP Phone Phone</td>
</tr>
<tr>
<td>Parent/Legal Guardian Name (if applicable)</td>
<td></td>
</tr>
</tbody>
</table>

**AGE IN MONTHS AT START OF RSV SEASON**

**ESTIMATED GESTATIONAL AGE AT BIRTH:**

**COMPLETED WEEKS**

**CHRONOLOGICAL AGE AT START OF RSV SEASON**

**GESTATIONAL AGE AT BIRTH OR DISEASE STATE**

☐ IF < 24 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT.

DATE OF BIRTH ON OR AFTER 11/02/2003 (SEE MEDICAID BULLETIN #190 FOR DETAILS RELATED TO CONGENITAL HEART DISEASE DIAGNOSES.)

☐ IF ≤ 12 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT.

DATE OF BIRTH ON OR AFTER 10/02/2004

☐ IF ≤ 6 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT.

DATE OF BIRTH ON OR AFTER 04/02/2005

☐ HEMODYNAMICALLY SIGNIFICANT HEART DISEASE: (SPECIFY ICD-9 CODE(S))

☐ CHRONIC LUNG DISEASE: (SPECIFY ICD-9 CODE(S))

AND AT LEAST ONE OF THE FOLLOWING:

☐ REQUIRED ROUTINE SUPPLEMENTAL OXYGEN WITHIN PAST 6 MONTHS:

☐ REQUIRED ANY OF THE FOLLOWING THERAPIES WITHIN THE PAST 6 MONTHS:

☐ IPRATROPium

☐ INHALED BETA 2 AGONIST

☐ METHYLXANTHINES

☐ STEROIDS (systemic or inhaled)

☐ SYMPATHOMIMETICS (e.g., epinephrine, isoproterenol)

☐ BETWEEN 28 & 31 COMPLETED WEEKS GESTATIONAL AGE AT BIRTH: (SPECIFY ICD-9 CODE):

☐ BETWEEN 32 & 35 COMPLETED WEEKS GESTATIONAL AGE: (SPECIFY ICD-9 CODE):

AND ONE OF THE FOLLOWING:

☐ SEVERE NEUROMUSCULAR DISEASE: (SPECIFY):

☐ CONGENITAL AIRWAY ANOMALY: (SPECIFY):

Bid

☐ BETWEEN 32 & 35 COMPLETED WEEKS GESTATIONAL AGE (SPECIFY ICD-9 CODE):

AND TWO OF THE FOLLOWING:

☐ DIRECT EXPOSURE TO TOBACCO SMOKE OR OTHER AIR POLLUTION

☐ ATTENDS CHILD CARE

☐ DIRECT CONTACT WITH SIBLINGS WHO ATTEND SCHOOL OR CHILD CARE

ADDITIONAL CLINICAL INFORMATION PERTAINING TO MEDICAL NECESSITY NOT OTHERWISE PROVIDED ABOVE:

---

**Rx:**

☐ Synagis® (palivizumab) 50mg and/or 100mg vials and Sterile Water for injection 10ml

**Sig:** Reconstitute as directed and inject 15mg/kg one time per month.

**Quantity:** QS for weight based dosing

☐ Syringes 1ml 25G 5/8”

☐ Epinephrine 1:1000 amp. Sig: Inject 0.01mg/kg as directed

☐ Other:

---

**Refills:** ____________

Physician Name (printed) ________________ Date ________________

Address __________________________________________________________

City ______________________ State _______ ZIP _______ Phone __________

Physician Signature ____________________________________________ Texas License No. ____________
### B.65 Texas Medicaid & Healthcare Partnership Electronic Remittance and Status (ER&S) Agreement (2 Pages)

**Before your ER&S Agreement* can be processed, you MUST choose ONE of the following:**

* These changes affect ONLY the ELECTRONIC version of the Remittance & Status Report. To make changes to the PAPER version of the R&S report, contact TMHP Provider Enrollment.

- **Set up INITIALLY** (first time). Use Production User ID*: ____________________________ (9 digits)
- **CHANGE** Production User ID
  - FROM: ____________________________ (9 digits)
  - TO: ____________________________ (9 digits)
- **REMOVE** Production ID
  - Remove: ____________________________ (9 digits)

**The TMHP Production User ID (Submitter ID) is the electronic mailbox ID used for downloading your Electronic Remittance & Status (ER&S) reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.**

**This information MUST be completed before your request can be processed.**

<table>
<thead>
<tr>
<th>Provider Name (must match TPI number)</th>
<th>BILLING TPI Number</th>
<th>Provider Tax ID Number</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Provider’s Physical Address</th>
<th>Provider Phone Number</th>
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<table>
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<tr>
<th>Provider Contact Name (if other than provider)</th>
<th>Provider Contact Title</th>
<th>Contact Phone Number</th>
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**Do not complete this block UNLESS the ER&S will be downloaded by anyone OTHER than the provider.**

<table>
<thead>
<tr>
<th>Name of Business Organization to Receive ER&amp;S</th>
<th>Business Organization Phone Number</th>
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<tr>
<th>Business Organization Contact Name</th>
<th>Business Organization Contact Phone No.</th>
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<thead>
<tr>
<th>Business Organization Address</th>
<th>Business Organization Tax ID</th>
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</table>

**Check each box after reading and understanding the following statements.**

If you are unsure about anything that is stated below, contact the TMHP EDI Help Desk at (888) 863-3638. All three statements must be checked before we can process your Electronic Remittance & Status Agreement.

- ☐ I (we) request to receive Electronic Remittance and Status information and authorize the information to be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.
- ☐ I (we) understand that paper–formatted R&S information will continue to be sent to my (our) accounting address as maintained at TMHP until I (we) submit an Electronic R&S Certification Request form.
- ☐ I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

<table>
<thead>
<tr>
<th>Provider Signature</th>
<th>Date</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Title</th>
<th>Email Address (if applicable)</th>
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**DO NOT WRITE IN THIS AREA — For Office Use**

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<thead>
<tr>
<th>Input By:</th>
<th>Input Date:</th>
<th>Mailbox ID:</th>
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</thead>
<tbody>
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</tbody>
</table>
Before faxing or mailing this agreement, ensure that all required information is completely filled out, and that the agreement is signed. Incomplete agreements cannot be processed.

Mail to: Texas Medicaid & Healthcare Partnership
       Attention: EDI Help Desk MC–B14
       PO Box 204270
       Austin, TX 78720-4270

Fax to: (512) 514-4228
       OR
       (512) 514-4230
B.66 Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Section I

Note: Please complete all information in the manner requested to ensure timely processing. **Otherwise additional information will be requested. This form is to be used for request of EITHER Intrathecal Baclofen or Morphine pump.

SECTION I: THE FOLLOWING MUST BE PROVIDED BY THE TREATING PHYSICIAN:

CLIENT NAME (LAST, FIRST, M.I.)  MEDICAID NUMBER  DATE OF BIRTH

CPT CODE(S) WITH DESCRIPTION OF PROCEDURE(S) REQUESTED: ________________________________

____________________________________________________________________________________

DATES OF SERVICE BEING REQUESTED  FROM: __________________  TO: _________________________

DIAGNOSIS OR ICD-9 CODE(S) AS RELATED TO PRESCRIPTION: ________________________________

____________________________________________________________________________________

PERFORMING PROVIDER NAME  PROVIDER SPECIALTY
(E.G., PEDIATRIC NEUROSURGEON)

PERFORMING PROVIDER ADDRESS: ________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

PERFORMING PROVIDER PHONE NUMBER: ________________________________________________
(INCLUDING AREA CODE)

PERFORMING PROVIDER TEXAS IDENTIFIER: _____________________________________________

NAME/LOCATION/PHONE NUMBER OF FACILITY WHERE PROCEDURE IS TO BE PERFORMED:
(ONLY APPLICABLE IF DIFFERENT FROM PROVIDER ADDRESS)

____________________________________________________________________________________

____________________________________________________________________________________

FACILITY TPI

_________  _________  ___________
ORIGINAL PHYSICIAN SIGNATURE  PRINTED NAME OF PHYSICIAN  DATE SIGNED
(STAMPED SIGNATURES NOT ACCEPTED)

**The completion of this form does not guarantee prior authorization. Once this information is reviewed and a determination has been made, you will receive a written response to the prior authorization request. If a prior authorization number is issued, it will be included in the response.

Eff. 01/29/99
B.67 Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Section II

Note: Please complete all information in the manner requested to ensure timely processing. **Otherwise additional information will be requested. This form is to be used for request of EITHER Intrathecal Baclofen or Morphine pump.

CLIENT NAME (LAST, FIRST, M.I.)   MEDICAID NUMBER   DATE OF BIRTH

SECTION 2: PLEASE ATTACH THE FOLLOWING INFORMATION AS IT APPLIES TO THIS REQUEST. THIS INFORMATION MUST BE SIGNED AND DATED BY THE PHYSICIAN (STAMPED SIGNATURES WILL NOT BE ACCEPTED):

1. History and Physical - include the following information:
   A. AGE OF ONSET OF SIGNS/SYMPTOMS, WHICH ARE DIRECTLY RELATED TO THIS REQUEST (IF REQUESTING BACLOFEN, SPECIFY MUSCLE GROUPS AFFECTED, DEGREE OF SPASTICITY, PARALYSIS, ETC.)
   B. PRIOR HOSPITALIZATIONS/TREATMENTS FOR THESE SYMPTOMS OR DIAGNOSES
   C. OTHER DIAGNOSES
   D. CURRENT LEVEL OF FUNCTIONING (ADLS)
   E. PERTINENT LAB/X-RAY RESULTS
   F. CLIENT'S WEIGHT (IN KILOGRAMS)
   G. FAMILY AND/OR CLIENT'S ROLE/PARTICIPATION/COMPLIANCE WITH CLIENT'S CARE
   H. MEDICATIONS (NAME, DOSAGE, ROUTE, AND FREQUENCY)
   I. RESPONSE OF CLIENT TO PRIOR TREATMENTS (MEDICATIONS)/SURGERY/ BACLOFEN/MORPHINE PUMP

2. PLAN OF CARE - INCLUDE INFORMATION PERTINENT TO THE TREATMENT PLAN. YOU DO NOT NEED TO DUPLICATE INFORMATION ALREADY CONTAINED IN THE “HISTORY AND PHYSICAL.” YOU MAY ATTACH YOUR MEDICAL CHART “PLAN OF CARE” FOR THIS SECTION IF IT IS SUCCINCT, COMPLETE, AND RESPONDS TO ALL OF THESE QUESTIONS.
   A. MEDICAL/SURGICAL MANAGEMENT OF CLIENT (CURRENT TREATMENT PLAN)
      1. MEDICAL PLAN OF CARE (MEDICATIONS, THERAPY, CONSULTS)
      2. SURGICAL PLAN OF CARE (E.G., CONSULTS, SCHEDULED SURGERIES)
      3. RECOMMENDATION AND PLAN OF CARE WITH A BACLOFEN/MORPHINE PUMP
         (including expected schedule of treatment, anticipated drug dosage, and volume and response evaluation, and if requesting Baclofen - muscle groups to be treated)
      4. FOLLOW-UP PLAN AND ANY ALTERNATIVES LONG-TERM
   B. ARE THERE ANY OTHER TREATMENTS, WHICH YOU EXPECT TO BE TRIED, IF THE BACLOFEN/MORPHINE IS INEFFECTIVE?
   C. LIST NAMES, SPECIALTIES, AND PHONE NUMBERS OF OTHER PHYSICIANS INVOLVED IN THE MULTIDISCIPLINARY CARE OF THIS CLIENT

** The completion of this form does not guarantee prior authorization. Once this information is reviewed and a determination has been made, you will receive a written response to the prior authorization request. If a prior authorization number is issued, it will be included in the response.

Eff. 01/29/99
B.68 Texas Medicaid Refund Information Form

Please attach this completed form to your refund check made payable to TMHP, include a copy of the Medicaid Remittance and Status (R&S) report, and mail to the following address:

Texas Medicaid & Healthcare Partnership
Financial Department
12357-B Riata Trace Parkway
Austin, TX 78727

Date: ___________________________ Refunding provider’s name: ____________________________________________
Provider’s TPI: ___________________ Provider contact name: ____________________________________________
Provider’s telephone number with extension: __________________________________________________________
Provider’s e-mail address: _______________________________________________________________________

Claim Information:
Medicaid claim number (from R&S) refund should be applied to: ________________________________________
Patient’s name: _________________________________________________________________________________
Patient’s Medicaid number: ________________________________________________________________________
Date(s) of service: ______________________________________________________________________________

Reason for the Refund:
_____ Other insurance paid $____________ on this claim. Attach EOB. If no EOB available, complete the following:

Insurance company name: _______________________________________________________________________
Address: ______________________________________________________________________________________
Telephone number: ___________________ Policy number: _____________________________________________

_____ TMHP audit identified overpayment
_____ Duplicate Medicaid payment
_____ Claim paid on the wrong patient’s Medicaid ID number
_____ Claim paid on the wrong provider’s Medicaid TPI
_____ Above-named person is not our patient
_____ Billing error
_____ Service was not rendered as billed
_____ Late credit for blood or pharmacy
_____ Medicare adjusted payment
_____ Patient’s Medicare eligibility
_____ Other (describe in detail): __________________________________________________________________

______________________________________________________________________________________________
B.69 TDHconnect Order Form

TDHconnect is the versatile, reliable, and free Windows-based claims submission software provided by TMHP. Technical support, upgrades, and training for TDHconnect are also available free from TMHP. Providers can use the software to submit claims, eligibility requests, claim status inquiries, adjustments, appeals, and to retrieve Electronic Remittance and Status (ER&S) reports. TDHconnect training can be obtained through the Provider Relations workshops. Information about these workshops and other classes related to Medicaid billing can be found at www.tmhp.com/Providers under TMHP Provider Services Representatives and TMHP Provider Workshops. Technical support for TDHconnect is available weekdays from 7a.m. to 7p.m. through the Electronic Data Interchange (EDI) Helpdesk at 1-888-863-3638. Technical support, software updates, and training are provided free of charge.

Mailing Information

<table>
<thead>
<tr>
<th>Provider or Organization Name</th>
<th>Provider Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
<td>Contact Number</td>
</tr>
</tbody>
</table>

Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

The TDHconnect software and Quick Start Guide should arrive within 15 business days of TMHP’s receipt of the order form. Overnight and 2nd Day services are available through UPS at the expense of the person(s) ordering TDHconnect. Orders received without a valid UPS account number or for any other package service will be sent through standard U.S. Mail. A signature is required for all UPS orders.

- Standard mail delivery
- UPS Overnight at provider’s expense
- UPS 2nd Day Air at provider’s expense

UPS Account Number: ________________________________

Authorized Signature: ________________________________

Title: ________________________________

Date: ________________________________ Telephone: 1-512-514-4228 or 1-512-514-4230

Fax Number: ________________________________

Mailing Address:
Texas Medicaid & Healthcare Partnership
Attention: EDI Helpdesk MC-B14
P.O. Box 204270
Austin, TX 78720-4270

Hardware and Software Requirements for TDHconnect

<table>
<thead>
<tr>
<th>Platforms</th>
<th>400 MHz or greater processor is recommended with 256MB of RAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Windows 98, Windows ME, Windows XP Home, Windows XP Pro, Windows NT 4.0 with Service Pack 5 or later, and Windows 2000 Pro</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hard Drive</th>
<th>Free space of 100MB for installation and 50MB per database</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Peripherals</th>
<th>CD-ROM Drive: Any speed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Display</td>
<td>800 X 600 VGA, 256 or more colors</td>
</tr>
<tr>
<td>Connectivity</td>
<td>9600bps minimum dial-up modem or Internet connection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Software</th>
<th>Adobe Acrobat Reader—latest version (Version 4.05 is included on the TDHconnect installation disk)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Internet Explorer—Version 6.0 or later</td>
</tr>
</tbody>
</table>
B.70  THSteps-CCP Prior Authorization Request Form

*****If any portion of this form is incomplete, it will be returned.*****

Request for:  □ DME   □ Supplies   □ Private Duty Nursing   □ Inpatient Rehabilitation   □ Other

Client Name (Last, First, MI) _____________________________________________________________

Medicaid Number (PCN) ___________________________ Date of Birth ___________________________

Name of Supplier/Vendor ________________________________________________________________

TPI ___________________________ Phone Number ___________________________

Phone Number ___________________________ FAX Number ___________________________

Address of Supplier/Vendor _____________________________________________________________

Diagnosis and Medical Necessity of requested services:

__________________________________________________________________________________________

__________________________________________________________________________________________

Dates of Service  From ___________________________ To ___________________________

HCPCS Code  Brief Description of requested services  Retail Price

_________  ________________________________________________________  _______

_________  ________________________________________________________  _______

_________  ________________________________________________________  _______

_________  ________________________________________________________  _______

_________  ________________________________________________________  _______

Note: HCPCS codes and description must be provided

By prescribing the identified DME and/or medical supplies, I certify to the following:

☐ The client is under 21 years of age AND

☐ The prescribed items are appropriate and can safely be used by the client when used as prescribed

For Private Duty Nursing, I certify:

☐ The client’s medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

Signature of prescribing physician __________________________________ Date ______________________

Printed or typed name of physician _________________________________________________________

Fax completed form to 1-512-514-4212

For TMHP Use Only

Or mail to:

CCP
PO Box 200735
Austin, TX 78720-0735
B.71 THSteps-CCP Prior Authorization Private Duty Nursing 4 or 6 Month Authorization

Name_________________________________________ Medicaid #___________________

The following criteria must be met before seeking a 4 or 6 month authorization of PDN services. Remember that authorization is a condition for reimbursement; it is not a guarantee. Each nurse provider should verify the continued Medicaid coverage for each client for each month of service.

____ Client has received PDN services for at least one year.

____ Client has had no new significant diagnosis, treatment, illness/injury or hospitalization in at least 6 months that would be expected to affect the need for PDN services.

____ There has been no change in the PDN requests in the previous 6 months.

____ Client’s physician and primary caregiver (parent) do not anticipate any significant changes in the client’s condition for the requested authorization period.

____ The nurse provider will ensure that a new Physician Plan of Care is obtained every 60 days and will be maintained with the client’s record.

____ The nurse provider will advise TMHP-CCP of any significant changes in the client’s condition, treatments or physician orders which occur during the authorization period if the number of PDN hours needs to change.

____ The client’s primary caregiver, personal physician and nurse provider understand that the authorization may be changed during the authorization period if the client’s condition or skilled needs change significantly.

All required acknowledgments must be signed and dated:

I have read and understand the above information.

______________________________________________________________________________________________

Brief statement of why a 4 or 6 month extension is appropriate for this client:

______________________________________________________________________________________________

I have discussed the above information with the client’s parent/primary caregiver.

______________________________________________________________________________________________

To be completed by the client’s physician:

The above services are medically necessary, the client’s condition is stable and this request supports the client’s health and safety needs.

______________________________________________________________________________________________

Fax completed request to TMHP-CCP at 1-512-514-4212

April 26, 2000
## B.72 THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>DOB:</th>
<th>Medicaid #:</th>
</tr>
</thead>
</table>

Has the child received therapy in the last year from the public school system? □ Yes □ No

Indicate the date of initial evaluation:  
PT  
OT  
SLP

Diagnoses:

Requested Treatment Plan. Indicate the date(s) of service and frequency per week or month:

<table>
<thead>
<tr>
<th>PT Service Date(s) FROM:</th>
<th>TO:</th>
<th>Frequency Per Week:</th>
<th>Per Month:</th>
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</thead>
<tbody>
<tr>
<td>OT Service Date(s) FROM:</td>
<td>TO:</td>
<td>Frequency Per Week:</td>
<td>Per Month:</td>
</tr>
<tr>
<td>SLP Service Date(s) FROM:</td>
<td>TO:</td>
<td>Frequency Per Week:</td>
<td>Per Month:</td>
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</table>

**New Application**: Have treatment goals been developed? □ Yes □ No

Is the child capable of making measurable progress? □ Yes □ No

**Renewal Application**: Has the child made measurable progress during this period? □ Yes □ No

Is the child capable of making continued measurable progress during this period? □ Yes □ No

Provider’s Name:

Billing Address (Street or PO Box)  
City  
State  
ZIP

Physician’s Name: (Please Print)  
Signature  
TPI  
Date

Therapist’s Name (PT): (Please Print)  
Signature  
TPI  
Date

Therapist’s Name (OT): (Please Print)  
Signature  
TPI  
Date

Therapist’s Name (SLP): (Please Print)  
Signature  
TPI  
Date
## B.73 THSteps Dental Mandatory Prior Authorization Request Form

Submit to:
THSteps Dental
Prior Authorization Unit
PO Box 202917
Austin, TX 78720-2917

**NOTE: ALL INFORMATION IS REQUIRED – PRINT CLEARLY OR TYPE**

<table>
<thead>
<tr>
<th>Patient’s Name and Address</th>
<th>Sex</th>
<th>Patient’s Birth Date</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>M ()</td>
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<td>F ()</td>
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<table>
<thead>
<tr>
<th>Medicaid Number</th>
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</table>

CHECK DIAGNOSTIC TOOLS SUBMITTED FOR REVIEW WITH AUTHORIZATION REQUEST:

FOR RESTORATIVE AND ICFMR:
- Panorex ( )
- FM X-ray ( )
- Periapicals ( )
- Documentation ( )

FOR ORTHODONTIC CASE, DIAGNOSTIC TOOLS MAILED:
- Models ( )
- Cephlometric X-ray ( )
- HLD ( )
- FM X-ray ( )
- Panorex ( )
- Photos ( )
- Documentations ( )
- Other:

DATE OF SERVICE DIAGNOSTIC TOOLS WERE PRODUCED:

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>TOOTH # OR LETTER</th>
<th>SURFACE</th>
<th>CHARGE</th>
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<tbody>
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</table>

**NOTE: ALL INFORMATION REQUIRED – PRINT CLEARLY OR TYPE**

<table>
<thead>
<tr>
<th>Signature of Dentist:</th>
<th>TPI</th>
<th>Dentist Address and ZIP</th>
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</table>

<table>
<thead>
<tr>
<th>Date:</th>
<th></th>
<th>Telephone Number</th>
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</tbody>
</table>
I understand and agree with the dentist’s assessment of my child’s behavior.

PARENT/GUARDIAN SIGNATURE: ______________________________________ DATE: ________________

Patients in need of general anesthesia who do not meet the 22-point threshold, by report, will require prior authorization.

**To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the patient chart. The patient chart must be available for review by representatives of TMHP and/or HHSC.**

PERFORMING DENTIST’S SIGNATURE: ______________________________________________________

DATE: ________________License No. ____________________________
Medicaid Dental Policy Regarding Criteria for Dental Therapy Under General Anesthesia—Attachment 1

Purpose: To justify I.V. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child’s Dental Record.

Elements: Note those required* and those as appropriate**:
1) * Patient’s Demographics including Date of Birth
2) * Relevant Dental and Medical Health History
   ** including Medical Evaluation Justifying Relevant Medical Condition(s)
3) * Dental Radiographs, Intraoral/Perioral Photography, and/or Diagram of Dental Pathology
4) * Proposed Dental Plan of Care
5) * Signed Consent by Parent/Guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of general anesthesia for dental care has been explained.
6) ** Description of Relevant Behavior and Reference Scale
7) ** Other Relevant Narrative Justifying Need for General Anesthesia
8) * Completed Criteria for Dental Therapy Under General Anesthesia form
9) * The dentist’s attestation statement and signature may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the chart as a stand-alone form:

“I attest that the patient’s condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the patient’s record and is available in my office.”

REQUESTING DENTIST’S SIGNATURE: ____________________________DATE: _______________
B.75  THSteps Referral Form Instructions

The referral form assists in relaying correct and pertinent information to the person or agency receiving the referral. It may be mailed or hand-carried by the client. When the form is returned, it should be placed in the client’s record.

Receiving/Referring Agencies
The name and address of both agencies should be completed to allow communication if additional information is necessary and to return a completed referral. If the referral is to a physician and the client is not able to name the physician who will be seen, this space may be completed MD/DO.

Identifying Information
This section concerning patient information should be as complete as possible. This section will assist the receiving agency to locate the client.

Reason for Referral
This section should contain information which is relevant to the referral. It may contain an assessment with request for further evaluation, or a request for intervention by a physician, hospital, or other agency involved with the client. Other information pertinent to the referral, such as family history or involvement with other agencies, may also be included.

Release of Information
This section must be signed.

Findings/Services Rendered
This final section provided the receiving agency the vehicle with which to transmit information back to originator of referral. Form may be mailed or carried by the client.
B.76 THSteps Referral Form

Referral date: ______________________

TO: Name and address of receiving agency or person
FROM: Name and address of person or agency referring

Client’s name: ___________________________ Social Security number: __________________
Address: _______________________________ Birth date: ________ Sex: (M)____(F)____
Telephone: ______________________________ DIRECTIONS TO HOME: __________________

REASON FOR REFERRAL:

RETURN RESPONSE REQUESTED

Signature/Title

Signature signifies receipt/knowledge of this referral and authorizes the referring agency to release information necessary for its completion, and the referring agency is released from all legal responsibility that may arise from this act.

Signature of Client/Parent/Guardian

FINDINGS AND SERVICES RENDERED:

1) White - Receiving Agency
2) Yellow - Receiving Agency Response
3) Pink - Client Record

Note: Instructions (L-29a) for use of Referral Form should accompany the document. (HHSC) L-29 Rev. (6/91)
B.77 Tort Response Form

Client Information

Today's Date _____/_____/______  Medicaid #______________________________

Client’s Date of Birth _____/_____/______  SSN_______/_______/___________

Client’s Last Name ______________________  First Name______________________________

Information Provided By:

Attorney _____ Insurance _____ Provider _____ Recipient _____ HHSC _____ Other _____

Name _____________________________  Phone #:_________________________

Accident Information

Date of Loss _____/_____/______  Type of Accident__________________

Case Comments______________________________

Attorney Information

Attorney’s Name ______________________________________________________________

Attorney’s Address ____________________________________________________________

Attorney’s Phone (____) _________________  Attorney’s Fax (____)__________________

Insurance Information

Insurance Company Name ________________________________________________________

Address _______________________________________________________________________

Adjuster’s Name ________________________  Claim #:________________________

Insured ___________________________  Policy #: _________________________

Phone (____) _______________________  Fax (____)_______________________

Fax or Mail completed copy to:

Texas Medicaid & Healthcare Partnership
Tort Department
PO Box 202948
Austin, TX 78720-9981
Fax: 1-512-514-4225

October 2005
B.78 Tuberculosis (TB) Screening and Education Tool Instructions

This screening tool for TB exposure risk is to be used annually to determine the need for tuberculin skin testing. The screening tool need not be done at visits for which tuberculin skin testing is required: ages 12-15 months and 5 years.

The questions in this screening tool are intended as a minimum screen. Follow-up questions may be necessary to clarify hesitant or ambiguous responses. Questions specific to TB exposure risks in the child’s community may need to be added.

- If all the answers are unqualified negatives the child is considered at low risk for exposure to TB and will not need tuberculin skin testing.
- If the answer to any question is “Yes” or “I don’t know,” the child should be tuberculin skin tested.
- In the case of the child for whom an answer in the past of “Yes” or “I don’t know” prompted a skin test, which was negative, the skin test may not have to be repeated annually.
- The decision to skin test must be made by the medical provider based upon an assessment of the possibility of exposure. A negative tuberculin skin test never excludes tuberculosis infection or active disease.
- BCG vaccinated children should also have the screening tool administered annually. Previous BCG vaccination is not a contraindication to tuberculin skin testing. Positive tuberculin skin tests in BCG vaccinated children are interpreted using the same guidelines used for non-BCG vaccinated children.
- Children who have had a positive TB skin test in the past (whether treated or not), should be re-evaluated at least annually by a physician for signs and symptoms of TB.

Care of children who are newly discovered to be tuberculin skin test positive includes:

- An evaluation for signs and symptoms of TB,
- A chest X-ray to rule out active disease,
- Oral medications to prevent progression to active disease or multi-drug therapy if active disease is present,
- Referral for consultation by a pediatric TB specialist is recommended if active disease is present,
- A report to the local health authority for investigation to find the source of the infection.

Feel free to photocopy the screening and education tool from this publication.
B.79 Tuberculosis (TB) Screening and Education Tool

Client Name: ____________________ Informant/Relationship: __________________________
DOB: ____________________________ Parent/Guardian:________________________________

This questionnaire is about tuberculosis. Tuberculosis can be transmitted to children by adults who live with or spend a great deal of time with them. Tuberculosis is transmitted by a person with tuberculosis to another person through airborne droplets that are coughed or sneezed into the air and breathed in by the child. This transmission of infection is more likely to occur when the child and the infectious person spend a lot of time together in a closed environment, like a small room, a car, or other similar situations.

Adults who have tuberculosis will often have the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills, and night sweats.

Children with tuberculosis frequently do not have symptoms.

A person can have a tuberculosis infection and not have active tuberculosis.
- Not everyone who coughs has tuberculosis.
- TB can cause (low-grade) fever of long duration, unexplained weight loss, failure to maintain adequate growth in children, weakness, chest pain, a bad cough, hoarseness, and/or coughing up blood.
- Tuberculosis is preventable and treatable.
- Children with active TB often do not show signs of illness. Infants are more likely to have symptoms.
- We need your help to find out if your child has been exposed to tuberculosis.

Since your child’s last skin test: Yes No I Don’t Know

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>I Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has anyone in your family had tuberculosis?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you know of any situation where your child was around an adult who has been diagnosed or suspected as having TB?</td>
<td></td>
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</tr>
<tr>
<td>Was your child born in or has your child visited a foreign country where there is a lot of TB?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, which country/countries?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB can cause fever of long duration, unexplained weight loss, weakness, chest pain, a bad cough, hoarseness or coughing up blood. Has your child been around anyone who has these problems?</td>
<td></td>
<td></td>
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<tr>
<td>Has your child had any of these problems?</td>
<td></td>
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<td></td>
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<tr>
<td>To your knowledge, has your child had contact with anyone who is/has been an intravenous (IV) drug user?</td>
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<tr>
<td>HIV-infected?</td>
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<tr>
<td>In jail/prison?</td>
<td></td>
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<tr>
<td>Recently moved to the US from a foreign country?</td>
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</tbody>
</table>

Interviewer: ______________________________________________________ Date of Interview: _______________
(Signature/Title)

7/00
B.80 Tuberculosis (TB) Screening and Education Tool (Spanish)

Client Name: ___________________________  Informant/Relationship: ___________________________
DOB: ___________________________________  Parent/Guardian: _______________________________

Este es un cuestionario sobre tuberculosis. Los adultos que viven o que pasan mucho tiempo con niños les pueden contagiar la tuberculosis. Esta enfermedad se transmite de una persona con tuberculosis a otra persona a través de gotitas que se tosen o se estornudan en el aire, y que el niño aspira. Es más fácil que ocurra esta trasmisión de la infección cuando el niño y la persona infectada pasan mucho tiempo juntos en un medio cerrado, como un cuarto pequeño, un carro, u otras situaciones similares.

Los adultos que tienen tuberculosis a menudo van a tener los síntomas siguientes: tos que dura más de dos semanas, pérdida del apetito, pérdida de diez libras o más en un período de tiempo corto, fiebre, escalofríos, y sudores de noche.

Los niños con tuberculosis frecuentemente no tienen síntomas.

Una persona puede estar infectada con tuberculosis, pero no tener la enfermedad activa.

- No todas las personas que tosen tienen tuberculosis.
- La tuberculosis puede causar una fiebre (baja) que dura mucho tiempo, una pérdida de peso que no se puede explicar, que los niños no crezcan como deben, debilidad, dolor en el pecho, una tos fuerte, estar ronco, y/o toser sangre.
- La tuberculosis puede prevenirse y tratarse.
- Los niños con tuberculosis activa muchas veces no parecen enfermos, pero es más probable que los bebés tengan síntomas.
- Necesitamos su ayuda para saber si su niño ha estado expuesto a la tuberculosis.

Desde la última prueba de la tuberculosis en la piel de su hijo o hija: Sí  No  No sé

<table>
<thead>
<tr>
<th>Alguien en su familia tuvo tuberculosis?</th>
<th>Sí</th>
<th>No</th>
<th>No sé</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usted sabe si hubo casos en que su hijo/hija estuvo con un adulto diagnosticado con TB, o que se sospecha tiene esta enfermedad?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Su hijo/hija nació o estuvo en un país donde hay mucha TB?</td>
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<tr>
<td>Si contestó Así, cuál fue el país o los países?</td>
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<tr>
<td>La TB puede causar fiebre que dura mucho tiempo, pérdida de peso que no puede explicarse, debilidad, dolor en el pecho, tos fuerte, ronquera o tos con sangre. Su hijo o hija ha estado con alguien que tiene estos problemas?</td>
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<tr>
<td>Por lo que usted sabe, su hijo o hija ha estado en contacto con alguien que usa o ha usado drogas intravenosas?</td>
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<td>que está infectado con HIV?</td>
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<td>que está o estuvo en la cárcel?</td>
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<tr>
<td>que recientemente se mudó de otro país a los Estados Unidos?</td>
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Interviewer: ___________________________________________________  Date of Interview: _______________

(Signature/Title)

7/00
B.81 Ventilator Service Agreement

Client Name: _____________________________ Client Medicaid Number: ________________________________

Provider Name: ____________________________ Medicaid Provider Number: _____________________________

Date of Ventilator Purchase: ________________ Date of Request: _____________________________________

Ventilator Make: ____________________________ Ventilator Model Number: ______________________________

Ventilator Serial Number: ___________________________________________________________________________

The Manufacturer’s recommended preventive maintenance schedule for the ventilator make and model must be submitted with the Ventilator Service Agreement request.

If this is a renewal Ventilator Service Agreement, in addition to the above, the following documentation must also be submitted:

1. Documentation of the monthly ventilator service procedures performed by a respiratory therapist and client assessments by a respiratory therapist.
2. Description of ventilator preventive maintenance performed during the last ventilator service agreement period:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

Provider responsibilities for maintaining the ventilator service agreement include:

1. Ensure routine service procedures outlined by the ventilator manufacturer are followed.
2. Provide all internal filters, all external filters and all ventilator circuits, (with the exhalation valve), as part of the ventilator service agreement payment.
3. Provide a respiratory therapist and a back-up ventilator on a 24-hour on call basis.
4. Provide monthly visits to the client’s home by a respiratory therapist to perform routine service procedures, monitor functioning of the ventilator system and assess client’s status. The provider must maintain documentation of monthly visits in accordance with Medicaid Records Retention Policy.
5. Provide a substitute ventilator while the manufacturers recommended preventative maintenance is being performed on the client owned ventilator.

The ventilator service agreement must be prior authorized every six (6) months.

_______________________________________________ ______________________
Provider Representative Signature                                 Date
B.82 Vision Care Eyeglass Patient (Medicaid Client) Certification Form

I, ___________________________________________________________, certify that:

Printed Name of Medicaid Client

(Check all that apply:)

_____ I was offered a selection of serviceable glasses at no cost to me, but I desired a type or style of eyewear beyond Medicaid program benefits. **I will be responsible for any balance for eyewear beyond Medicaid program benefits.**

My selection(s) beyond Medicaid benefits were:

1.___________________________________________________

2.___________________________________________________

3.___________________________________________________

4.___________________________________________________

_____ The glasses that are being replaced were unintentionally lost or destroyed.

_____ I picked up/received the eyewear.

__________________________________________    __________________________________________
Medicaid Client Signature                                                Witness Signature

__________________________________________    __________________________________________
Date                                                                                   Date

_________________________________________
Medicaid Client Identification Number

_________________________________________
Medicaid TPI
B.83 Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish)

Yo, ____________________________________________________________________, declaro que:

Nombre de cliente de Medicaid

(Marque todos los que apliquen)

_____ Yo necesito reemplazar los lentes que tengo. Me ofrecieron una selección de lentes gratis, pero deseo otro tipo que no está incluido en el programa de Medicaid. **Yo entiendo que tendré que pagar por la diferencia.**

La selección(es) de lentes que escogí fue:

1.___________________________________________________

2.___________________________________________________

3.___________________________________________________

4.___________________________________________________

_____ Los lentes que van a ser reemplazados no fueron perdidos o destruidos intencionalmente.

_____ Yo recibí los lentes.

__________________________________________    __________________________________________
Firma de Testigos  Firma del Cliente

__________________________________________    __________________________________________
Fecha  Fecha

__________________________________________
El número de identificación de Medicaid

__________________________________________
Identificación de proveedor de Texas
B.84 Wheelchair Seating Evaluation Form (THSteps-CCP/Home Health Services) (Next 6 Pages)

CLIENT’S NAME: ___________________________________________________________

CLIENT’S MEDICAID #: ______________________________ DATE OF BIRTH:____________________________

DIAGNOSIS: ________________________________________________________________

HT: ___ WT: ___

------------------------------

Complete I-VI for manual wheelchairs
Complete I-VII for power wheelchairs

I. NEUROLOGICAL FACTORS

Indicate client’s muscle tone:

- Hypertonic □
- Absent □
- Fluctuating □
- Other □

Describe client’s muscle tone:

Describe active movements affected by muscle tone:

Describe passive movements affected by muscle tone:

Describe reflexes present:

NOTE: A CURRENT WHEELCHAIR SEATING ASSESSMENT CONDUCTED BY A PHYSICAL OR OCCUPATIONAL THERAPIST MUST BE COMPLETED FOR PURCHASE OF OR MODIFICATIONS (INCLUDING NEW SEATING SYSTEMS) TO A CUSTOMIZED WHEELCHAIR. PLEASE ATTACH MANUFACTURER INFORMATION, DESCRIPTIONS AND AN ITEMIZED LIST OF RETAIL PRICES OF ALL ADDITIONS THAT ARE NOT INCLUDED IN BASE MODEL PRICE.
## II. POSTURAL CONTROL:

<table>
<thead>
<tr>
<th></th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>None</th>
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<tbody>
<tr>
<td>Head Control:</td>
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<tr>
<td>Trunk Control:</td>
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</tr>
<tr>
<td>Upper Extremities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower Extremities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## III. MEDICAL/SURGICAL HISTORY AND PLANS:

<table>
<thead>
<tr>
<th>Is there history of decubitis/skin breakdown?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, please explain:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Describe orthopedic conditions and/or range of motion limitations requiring special consideration (e.g., contractures; degree of spinal curvature):

Describe other physical limitations or concerns (i.e. respiratory):

Describe any recent or expected changes in medical/physical/functional status:

If surgery is anticipated, please indicate the procedure and expected date:

## IV. FUNCTIONAL ASSESSMENT:

<table>
<thead>
<tr>
<th>Ambulatory Status:</th>
<th>Non-ambulatory</th>
<th>With assistance</th>
<th>Short distances only</th>
<th>Community ambulatory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Indicate the client’s ambulation potential:

- expected within 1 year
- not expected
- expected in future within ___ years

Wheelchair Ambulation:

- Is client totally dependent upon wheelchair? Yes | No |

If no, please explain:
<table>
<thead>
<tr>
<th>Indicate the client’s transfer capabilities:</th>
<th>moderate assistance</th>
<th>independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>maximum assistance</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>minimum assistance</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeding:</th>
<th>moderate assistance</th>
<th>independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>maximum assistance</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>minimum assistance</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the client tube fed?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, please explain:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dressing:</th>
<th>moderate assistance</th>
<th>independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>maximum assistance</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>minimum assistance</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Describe other activities performed while in wheelchair:

**V. ENVIRONMENTAL ASSESSMENT**

Describe where client resides:

<table>
<thead>
<tr>
<th>Is the home accessible to the wheelchair?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are ramps available in the home setting?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Describe the client’s educational/vocational setting:

<table>
<thead>
<tr>
<th>Is the school accessible to the wheelchair?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there ramps available in the school setting?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If client is in school, has a school therapist been involved in the assessment? | Yes | No |

Name of school therapist:  
Name of school:  
School therapist’s phone #:  

Describe how the wheelchair will be transported?
Describe where the wheelchair will be stored? *(home and/or school)*

Describe other types of equipment which will interface with the wheelchair?

**VI. REQUESTED EQUIPMENT:**

Describe client’s current seating system, including the mobility base and the age of the seating system:

Describe why current seating system is not meeting client’s needs:

Describe the equipment requested:

Describe the medical necessity for mobility base requested:

Describe the medical necessity for the seating system requested:

Describe the growth potential of equipment requested in number of years: ________

Describe any anticipated modifications/changes to the equipment within the next three years:

Therapist’s name: Therapist’s signature: 

Therapist’s title: Date:

Therapist’s phone number: (_____) ____________________

Therapist’s employer: *(name)*: Therapist’s address: *(work or employer address)*
### VII. POWER WHEELCHAIRS: *(Complete if a power wheelchair is being requested)*

Describe the medical necessity for power vs. manual wheelchair:
*(Justify any accessories such as power tilt or recline)*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is client unable to operate a manual chair even when adapted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is self propulsion possible but activity is extremely labored?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>If yes, please explain:</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is self propulsion possible but contrary to treatment regimen?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>If yes, please explain:</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How will the power wheelchair be operated? <em>(hand, chin, etc.)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the client physically and mentally capable of operating power wheelchair safely and with respect to others?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is the caregiver capable of caring for power wheelchair and understanding how it operates?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>How will training for the power equipment be accomplished?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Therapist’s name:   Therapist’s signature:
Therapist’s title:  Date:
Therapist’s phone number:   (______)  ________________
Therapist’s employer: *(name)*  Therapist’s address: *(work or employer address)*
HOME HEALTH/CCP MEASURING WORKSHEET

CLIENT’S NAME: __________________________
CLIENT’S MEDICAID #: __________________
DATE OF BIRTH: _________________________
HEIGHT: __________ WEIGHT: ____________
DATE WHEN MEASURED: ________________
MEASURER’S NAME: _____________________
MEASURER’S PHONE #: __________________

1. ________ 1. Top of head to bottom of buttocks
2. ________ 2. Top of shoulder to bottom of buttocks
3. ________ 3. Arm pit to bottom of buttocks
4. ________ 4. Elbow to bottom of buttocks
5. ________ 5. Back of buttocks to back of knee
6. ________ 6. Foot length
7. ________ 7. Head width
8. ________ 8. Shoulder width
9. ________ 9. Arm pit to arm pit
10. ________ 10. Hip width
11. ________ 11. Distance to bottom of left leg
( popliteal to heel)
12. ________ 12. Distance to bottom of right leg
( popliteal to heel)

ADDITIONAL COMMENTS:
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________

(Images of measurement points labeled 1 to 12)