CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form and Instructions

General Information

- Ensure the most recent version of the CSHCN Services Program Prior Authorization Home Health (Skilled Nursing) Request and Treatment Plan Form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form,** according to the instructions. Signatures are required as indicated.
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for assistance with this form.
- This form may be submitted by mail to the following address:

TMHP-CSHCN Services Program Authorization Department
12365-A Riata Trace Pkwy., Ste. 100
Austin, TX 78727

- This form may be submitted by fax to 1-512-514-4222.
- Submit only the referral and treatment plan form. Do not submit instruction pages.
- **Refer to:** The "Home Health (Skilled Nursing) Care" section of the current *CSHCN Services Program Provider Manual*.

Prior Authorization Request Submitter Certification Statement

Description
Read the certification statement and select "We Agree."

Client Information

Field Description	Guidelines
First name*	Enter the client's first name as indicated on the CSHCN Services Program eligibility form.
Last name*	Enter the client's last name as indicated on the CSHCN Services Program eligibility form.
CSHCN Services Program number*	Enter the client's ID number as indicated on the CSHCN Services Program eligibility form.
Date of birth*	Enter the client's date of birth as indicated on the CSHCN Services Program eligibility form.
Address/City/State/ZIP Code	Enter the client's address, city, state, and ZIP Code.
Diagnoses	Enter the diagnosis code(s) relevant to the client's condition.

Requested Services

Field Description	Guidelines
Initial start of care date (mm/dd/yy)	Indicate client's initial prior authorized start of care date.
Start of care date (mm/dd/yy) *	Indicate the start of care date.
End of care date (mm/dd/yy) *	Indicate the end of care date.
Request status	Indicate the request status (new, extension, or revision).
Type of service*	Indicate the required skilled nursing (registered nurse [RN] or licensed vocational nurse [LVN]), home health aide (HHA), extended skilled nursing or as needed (PRN) skilled nursing services requested. Include hours per day, days per week, and number of weeks including totals.
Attach Home Health Plan of Care (POC)	Include the Home Health POC with this prior authorization form.

Field Description	Guidelines
Attach Client Assessment	Include the client assessment with this prior authorization form.
Additional comments	Indicate any additional information that is relevant to this request.

If hours from a previous authorization were not used, complete the following:

Field Description	Guidelines
Service dates affected	Enter the affected service dates.
Original number of hours requested for the service dates	Enter the original number of hours requested for the service dates.
Actual number of hours used for these service dates	Enter the actual number of hours used for the service dates.
Reason hours were not used	Enter the reason hours were not used.
RN/LVN name	Enter the RN or LVN's name.
RN/LVN signature	RN or LVN must sign in this field.
Date	Enter the date the form was signed.
Telephone number	Enter the RN or LVN's telephone number.

Home Health Agency Provider Information and Required Signature

Field Description	Guidelines
Rendering provider name*	Enter the rendering provider's name.
Other contact name (if any)	Enter the contact's name.
Tax ID*	Enter the provider's Tax ID.
NPI*	Enter the provider's national provider identifier (NPI).
Taxonomy code*	Enter the provider's taxonomy code.
Benefit code*	Enter CSN.
Provider contact name	Enter the provider's contact name.
Telephone number	Enter the provider's telephone number.
Fax number	Enter the provider's fax number.
Address/City/State/ZIP*	Enter the provider's address, city, state, and ZIP + 4.
Home health agency provider signature	Home health agency provider must sign in this field.
Date	Enter the date the form was signed.

Section B: Completed by the Requesting Practitioner

Client Information

Field Description	Guidelines
First Name*	Enter client's first name.
Last Name*	Enter client's last name.
CSHCN Services Program number*: 9-_____-00	Enter the CSHCN Services Program number.

CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form and Instructions

Requesting Practitioner Information and Required Signature

Field Description	Guidelines
Recent health history	Indicate client's recent health history.
Brief statement of medical necessity for in-home skilled nursing services	Enter a brief statement of medical necessity for in-home skilled nursing services.
Treatments ordered, including frequency and duration	Enter the treatments ordered, including frequency and duration.
Medications (primary) dose, route, frequency	Indicate the primary medications, including dose, route, and frequency.
Equipment or supplies required	Indicate equipment or supplies required.
Functional limitations/ Permitted Activities/ Homebound status	Indicate client's functional limitations, permitted activities, and homebound status.
Nutritional requirements	Indicate the nutritional requirements.
Safety of precautionary measures	Indicate the safety of precautionary measures.
Developmental/functional status	Indicate the client's developmental and functional status.
Mental Status	Indicate the client's mental status.
Prognosis	Indicate client's prognosis.
Rehab potential	Indicate client's rehab potential.
Date last seen by physician, APRN, or PA	Enter the date the client was last seen by physician, APRN or PA, ordering SN, HHA, or extended SN services.
Progress summary	Enter the progress notes.
Discharge planning	Indicate the plan for discharging client from SN, HHA, or extended SN services.
Requesting practitioner name*	Enter the physician, APRN, or PA name.
Requesting practitioner signature	Physician, APRN, or PA signature is required.
Telephone number	Enter the physician, APRN, or PA telephone number.
Date	Enter the date the form was signed.
Requesting practitioner license number	Enter the license number of the physician, APRN, or PA.
NPI*	Enter the NPI of the physician, APRN, or PA.

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. To submit by fax, send to **512-514-4222**.

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *CSHCN Services Program Provider Manual*.

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's CSHCN Services Program enrollment and/or personal exclusion from the CSHCN Services Program.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in *the CSHCN Services Program Provider Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

Section A: Completed by the Home Health (Skilled Nursing) Provider

Client Information:			
First name*:		Last name*:	
CSHCN Services Program number*: 9-_____-00		Date of birth*:	
Address/City/State/ZIP Code:			
Diagnoses:			
Requested Services:			
Initial start of care date (mm/dd/yy):			
Start of care date (mm/dd/yy)*:		End of care date (mm/dd/yy)*:	
Request status:	☐ New	☐ Extension	☐ Revision

Type of Service*	**Hours/Day**	**x Days/Week**	**x No. of Weeks**	**= Total Hours**
Skilled nursing (RN) hours, procedure code G0299				
Skilled nursing (LVN) hours, procedure code G0300				
HHA hours, procedure code G0156				
PRN skilled nursing hours, procedure code G0299 (RN hours)				
PRN skilled nursing hours, procedure code G0300 (LVN hours)				
Extended skilled nursing hours, RN, procedure code S9123				
Extended skilled nursing hours, licensed practical nurse (LVN), procedure code S9124				
Sum of total hours requested:				

☐ **Attach Home Health Plan of Care (POC)**	☐ **Attach Client Assessment**

Additional Comments:		
If hours from a previous authorization were not used, complete the following:		
Service dates affected:		
Original number of hours requested for the service dates:		
Actual number of hours used for these service dates:		
Reason hours were not used:		
RN/LVN name:	RN/LVN signature:	
Date:	Telephone:	
Rendering Home Health Agency Provider Information and Required Signature:		
Rendering provider name*:	Other contact name (if any):	
Tax ID*:	NPI*:	
Taxonomy code*:	Benefit code*: **CSN**	
Telephone:	Fax:	
Street address*:		
City:	State:	ZIP + 4*:
Home health agency provider signature:		Date:

Section B: Completed by the Requesting Practitioner

Client Information:	
First name*:	Last name*:
CSHCN Services Program number*: 9-_____-00	
Requesting Practitioner Information and Required Signature: **The following information must be completed by a physician, APRN, or PA.**	
Recent health history:	
Brief statement of medical necessity for in-home skilled nursing services:	
Treatments ordered, including frequency and duration:	
Medications (primary), dose, route, frequency:	
Equipment or supplies required:	
Functional limitations/Permitted activities/Home bound status:	
Nutritional requirements:	
Safety or precautionary measures:	

CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form and Instructions

Developmental/functional status:
Mental Status:
Prognosis:
Rehab potential:
Date last seen by physician, APRN, or PA:
Progress summary:
Discharge planning:
My signature attests that the client named above requires care as requested on the CSHCN Services Program Prior Authorization Home Health (Skilled Nursing) Request and Plan of Care Form.
Requesting practitioner name (typed or printed*):
Requesting practitioner signature:

Telephone:	Date:
Ordering practitioner license number:	
NPI*:	