

CSHCN Services Program Prior Authorization Request for Diapers, Pull-ups, Briefs, or Liners Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Diapers, Pull-ups, Briefs, or Liners form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Incomplete **prior authorization** requests are denied. Requests are considered only when completed and received before the service is provided.
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, 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 prior authorization form. Do not submit instruction pages.
- **Refer to:** The "Expendable Medical Supplies" chapter in the current *CSHCN Services Program Provider Manual*.
- This form is required if the client's medical need exceeds a combination of 240 diapers, pull-ups, briefs, or liners, or for clients who do not have a diagnosis listed in the CSHCN Services Program Provider Manual.
- Clients must be 4 years of age or older and be incontinent as a direct complication of a medical condition.

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	Enter the client's address, city, state, and ZIP
Diagnoses	Enter the diagnosis codes(s) relevant to the need for diapers, pull-ups, briefs, or liners

Product Information

Field Description	Guidelines
Product type	Check the appropriate product type
Quantity needed per month*	Indicate the quantity needed per month (Exceeding the 240 limitation)
Procedure code*	Indicate the procedure code
Document medical necessity for additional products	Document the medical necessity for additional products

Unlisted Diagnosis Information

Field Description	Guidelines
Indicate unlisted diagnosis	Enter the unlisted diagnosis
Document medical necessity for unlisted diagnosis	Document the medical necessity for an unlisted diagnosis

Vendor Information and Required Signature

Field Description	Guidelines
Rendering vendor name*	Enter the vendor's name
Tax ID*	Enter the vendor's Tax Identification Number (TIN)
NPI*	Enter the vendor's national provider identifier (NPI)
Taxonomy code*	Enter the vendor's taxonomy code
Benefit code*	Enter DM3
Telephone	Enter the vendor's telephone number
Fax	Enter the vendor's fax number
Address/City/State/ZIP*	Enter the vendor's address, city, state, and ZIP + 4
Signature	Vendor must sign in this field
Date	Enter the date the form is signed

Physician Information and Required Signature

Field Description	Guidelines
Requesting physician name*	Enter the requesting physician's name
NPI*	Enter the requesting physician's NPI
Telephone	Enter the physician's telephone number
Fax	Enter the physician's fax number
Signature	Physician must sign in this field
Date	Enter the date the form is signed

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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

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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.

This form is required if the client's medical need exceeds a combination of 240 diapers, pull-ups, briefs, or liners, or for clients who do not have a diagnosis listed in the <i>CSHCN Services Program Provider Manual</i> .			
Client Information:			
First name*:		Last name*:	
CSHCN Services Program number*: 9-_____ -00		Date of birth*:	
Address/City/State/ZIP:			
Diagnoses:			
Product Information:			
<input type="checkbox"/> Diapers	Quantity needed per month*: _____	Procedure Code*: _____	
<input type="checkbox"/> Pull-ups	Quantity needed per month*: _____	Procedure Code*: _____	
<input type="checkbox"/> Briefs	Quantity needed per month*: _____	Procedure Code*: _____	
<input type="checkbox"/> Liners	Quantity needed per month*: _____	Procedure Code*: _____	
Document medical necessity for additional products:			
Unlisted Diagnosis Information:			
Indicate unlisted diagnosis:			
Document medical necessity for unlisted diagnosis:			
Rendering Vendor Information and Required Signature:			
Rendering vendor name*:		Vendor contact name:	
Tax ID*:	NPI*:	Taxonomy*:	Benefit code*:
Telephone:		Fax:	
Street address*:			
City:		State:	ZIP + 4*:
Signature:		Date:	
Requesting Physician Information and Required Signature:			
Requesting physician name (printed or typed)*:			
NPI*:			
Physician contact name:		Telephone:	Fax:
Signature:		Date:	