Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form

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 *Texas Medicaid Provider Procedures Manual* (TMPPM).

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 Medicaid enrollment and/or personal exclusion from Texas Medicaid.

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 relevant Texas Medicaid Provider Procedures 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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Comprehensive Care Program (CCP) Fax: 1-512-514-4212	Special Medical Prior Authorization (SMPA) Fax: 1-512-514-4213	Home Health (HH) Services Fax: 1-512-514-4209

Client Name:			
Medicaid Number:		Date of Birth:	
Condition: ☐ **Acute** ☐ **Chronic**	If acute condition, enter date(s) of onset and exacerbation:		
Treatment Diagnoses:		Other Diagnoses:	
Has the client received therapy in the last year from the public school system? ☐ Yes ☐ No			

Place of Service Requested (please check *one* of the following):

☐ Office	☐ Outpatient	☐ Home	☐ Other, specify:

Date of Last Therapy Evaluation or Re-Evaluation	PT:	OT:	ST:

Attach a copy of the therapy evaluation/re-evaluation or progress summary (acute) for each therapy discipline requested below. Provide all other required documentation for an authorization as listed in the *Texas Medicaid Provider Procedures Manual*.

Discipline and Modifier	Dates of Service		Projected Frequency (per week or per month) *	Total Number of Units or Visits Requested
	From	Through		
PT (GP)				
OT (GO)				
ST (GN)				

* If projected frequency will be tapered down or variable, indicate frequency plans here. If client is to be discharged, write "discharged" and date of discharge in this space:

Procedure Codes Requested:

Specialist	Printed Name	Signature	Date
Physical Therapist			
Occupational Therapist			
Speech Therapist			
Prescribing Provider			

Prescribing Provider NPI and License No.:

Date client last seen by prescribing provider:

The provider's signature certifies the client's medical record includes a completed, signed and dated Plan of Care (POC) that contains all elements of the Texas Medicaid POC, including, for clients birth through 20 years of age, a current Texas Health Steps checkup or developmental screening performed within the last 60 calendar days.

The form may be submitted without the prescribing providers' signature and date; however, one of the following must be submitted with the request: a signed and dated prescription, a dated written order, or a dated documented verbal order.

Therapy Billing Provider Information

Name:			Telephone:
Address:			Fax:
TPI:	NPI:	Taxonomy:	Benefit Code: