

Outpatient Withdrawal Management Authorization Request Form

Submit your prior authorization using TMHP's Prior Authorization (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. Faxed requests must be scanned and data entered before the PA Department receives them, which takes up to 24 hours. To access PA on the Portal, go to www.tmhp.com, click on "Providers," then "Prior Authorization" from the left hand menu. Then click "PA on the Portal" from the left hand menu and enter your TMHP Portal account user name and password. To submit by fax, send to 1-512-514-4211. Or mail to:

Texas Medicaid & Healthcare Partnership
Attn: TMHP
12357-B Riata Trace Parkway, Suite 100
Austin, Texas 78727-6422

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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Attach a comprehensive assessment of client history, treatment plan, and/or progress notes to support medical necessity.

A. Client Information		
Client Name (<i>Last, First, M.I.</i>):		
Medicaid Number:		Date of Birth:
Age:	Sex:	Date of Submission:
Date Current Treatment Began:		Time:
B. Chemical Dependency Treatment Facility Information		
Facility Name:		Contact Person:
Address (Street/City/State/ZIP):		
Telephone:		Fax:
TPI:		NPI:
For admission requests, complete all sections except section G		
C. Criteria for Admission		
The individual is expected to have a stable withdrawal from alcohol/drugs:	Yes	No
Client has a seizure disorder or history of seizures during substance withdrawal	Yes	No
Disorientation to self:	Yes	No
Alcoholic hallucinosis:	Yes	No
Toxic psychosis:	Yes	No
Stable vital signs without a history of past acute withdrawal syndromes:	Yes	No
Presence of any presumed new asymmetric and/or focal findings:	Yes	No
Altered level of consciousness:	Yes	No
Clinical condition allows for a comprehensive assessment:	Yes	No
Serious disulfiram-alcohol (Antabuse) reaction:	Yes	No
D. Family, social, academic dysfunction		
Client's social system/significant others are supportive of recovery to the extent that the client can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the client's addiction:	Yes	No
Client's family/significant others are willing to participate in the outpatient withdrawal management program:	Yes	No
Client has the social skills to obtain such a support system and/or to become involved in a self-help fellowship:	Yes	No
Client lives in environment where licit/illicit mood altering substances are used:	Yes	No

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E. Emotional/behavioral status		
Client is coherent, rational, and oriented for treatment:	Yes	No
Client can comprehend and understand the materials presented:	Yes	No
Client can participate in outpatient withdrawal management process:	Yes	No
Client expresses an interest to work toward withdrawal management goals:	Yes	No
Client is free of neurological, psychological, or uncontrolled behavior that places the individual at imminent risk of harming self or others:	Yes	No
Client is free of mental confusion or fluctuating orientation:	Yes	No
F. Recent chemical substance use		
Client's chemical substance use is excessive, and the client has attempted to reduce or control it, but has been unable to do so:	Yes	No
Client is motivated to stop using alcohol/drugs, and is in need of a supportive structured treatment program to facilitate withdrawal from chemical substances:	Yes	No
G. Continued Stay Criteria for Outpatient Withdrawal Management (Complete only sections A, B, G, H, I, and J if additional withdrawal management days are needed)		
Client, while physically abstinent from chemical substance use, exhibits incomplete stable withdrawal from alcohol/drugs, evidenced by psychological and physical cravings:	Yes	No
Client, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol/drugs, as evidenced by significant drug levels:	Yes	No
Documentation in the medical record indicates an intervening medical or psychiatric event which was serious enough to interrupt outpatient withdrawal management, but the client is again progressing in treatment:	Yes	No
H. Current DSM Diagnoses:		
I. Number of withdrawal management days requested:		
Dates from: _____ to: _____		
J. Provider Information		
Provider Printed Name:	Provider License No.:	
QCC Signature <i>(stamped signatures not accepted)</i>	Date	