# CSHCN Services Program Request for Authorization and Prior Authorization Request Form and Instructions

**General Information**

- ***Use this form only if a form is not available for a specific service.***
- Ensure the most recent version of this form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Incomplete ***authorization*** requests will cause the claim to be denied.
- 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
12357-B Riata Trace Parkway Ste #100 MC-A11
Austin, TX 78727

- This form may be submitted by fax to 1-512-514-4222.
- Submit only the authorization form. Do not submit instruction pages.

**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 |
| Diagnosis | Enter the diagnosis code relevant to the client's condition. |

**Requested Procedure or Service Information**

| Field Description | Guidelines |
|---|---|
| Type of request | Check the appropriate type of service being requested |
| Procedure requested (per CPT code) | Indicate the procedure code for the service being requested |
| Service requested | Indicate a brief description of the service requested |
| Other | Indicate any other information applicable to the request |
| Diagnosis | Indicate a diagnosis code relevant to the request |
| Additional information | Refer to the appropriate manual section for other specific authorization requirements |

**Statement of Medical Necessity**

| Field Description | Guidelines |
|---|---|
| Document medical necessity | Document medical necessity |
| Provider's name | Enter requesting provider's name |

| Field Description | Guidelines |
|---|---|
| Telephone number | Enter requesting provider's telephone number |
| Provider's signature | Requesting provider must sign in this field |
| Date signed | Enter the date the form is signed |

**Provider Information and Required Signature**

| Field Description | Guidelines |
|---|---|
| Provider name | Enter provider's name |
| Contact person | Enter the contact person's name |
| CSHCN TPI | Enter the provider's CSHCN Texas provider identifier (TPI) |
| NPI | Enter the provider's national provider identifier (NPI) |
| Taxonomy code | Enter the provider's taxonomy code |
| Benefit code | Enter CSN |
| 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 |
| Provider signature | Provider must sign in this field |
| Date | Enter the date the form is signed |

**Additional Requirements**

- For additional requirements needed for the request, refer to the specific service chapter in the *CSHCN Services Program Provider Manual*.

# CSHCN Services Program Authorization and Prior Authorization Request

## 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

# CSHCN Services Program Authorization and Prior Authorization Request

**This form is used only for authorization and prior authorization requests for services for which a form is not available.**

## Client Information

| | |
|---|---|
| First name: | Last name: |
| CSHCN Services Program number: 9-_____-00 | Date of birth: |
| Address/City/State/ZIP: | |
| | |
| Diagnosis: | |

## Requested Procedure or Service Information

Type of request: ☐ Authorization ☐ Prior authorization

| | |
|---|---|
| Procedure requested (per CPT code): | Service requested: |
| Other: | Diagnosis: |

**Additional information** (*Refer to the appropriate manual section for specific authorization requirements*):

## Statement of Medical Necessity

**Document medical necessity:**

*I certify that the patient's medical condition is such that the treatment requested above is medically necessary.*

| | |
|---|---|
| Provider's name: | Telephone number: |
| Provider's signature: | Date signed: |

## Provider Information and Required Signature

| | |
|---|---|
| Provider name: | Contact person: |
| CSHCN TPI: | NPI: |
| Taxonomy code: | Benefit code: |
| Telephone number: | Fax number: |
| Address/City/State/ZIP: | |
| Provider signature: | Date: |