CSHCN Services Program Request for Authorization and Prior Authorization Request 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
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 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.

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Field Description	Guidelines
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.
Requesting provider's name*	Enter requesting provider's name.
NPI*	Enter the requesting provider's NPI.
Telephone number	Enter requesting provider's telephone number.
Requesting 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
Rendering provider name*	Enter the rendering provider's name.
Contact person	Enter the contact person's name.
Tax ID*	Enter the provider's Tax Identification Number (TIN).
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 + 4.
Rendering 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 Request for Authorization and Prior Authorization Request Form

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 username and password. To submit by fax, send to **512-514-4212**.

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 relevant *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 Request for Authorization and Prior Authorization Request Form

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

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.*

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.			
Requesting provider's name*:		NPI*:	Telephone:
Requesting provider's signature:			Date signed:
Rendering Provider Information and Required Signature			
Rendering provider name*:		Contact person:	
Tax ID*:	NPI*:	Taxonomy*:	Benefit Code*:
Telephone:		Fax:	
Street address*:			
City:		State:	ZIP + 4*:
Rendering provider signature:			Date:

* Essential/Critical field