CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1) Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Initial Outpatient Therapy (TP1) 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 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 can be submitted to TMHP using the TMHP **PA on the Portal** (click "PA on the Portal" and enter your TMHP portal account username and password).
- With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision.
- This form can also be submitted by fax to 1-512-514-4222, or submitted by mail to the following address:

TMHP-CSHCN Services Program
Prior Authorization Department
12357-B Riata Trace Parkway Ste #100 MC-A11
Austin, TX 78727

- Submit only the prior authorization form. Do not submit instruction pages.
- **Refer to:** Chapter 30, "Physical Medicine and Rehabilitation" and Chapter 36, "Speech-Language Pathology (SLP) Services" in the current *CSHCN Services Program Provider Manual*.

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
Therapy in school district	Check if the client receives therapy through a school district. If "yes," indicate how services requested through CSHCN Services Program will differ.
Diagnosis code(s)	Enter the diagnosis code(s) relevant to the client's condition

Evaluation Summary

Field Description	Guidelines
Date of evaluation	Enter the date of evaluation. ***Note:*** *A copy of the initial evaluation must be attached.*
Type of evaluation	Check the appropriate type of evaluation
Comments	

Service Request

Field Description	Guidelines
Service request	Indicate procedure code(s), modifier, the dates of service, and the frequency per week or month. Dates of service cannot exceed six months. If possible, end requested date(s) of service on the last day of a month.
Physician name, signature, and date	Indicate the prescribing physician's name, signature, and date of signature
PT name, signature, and date	Indicate the physical therapist's name, signature, and date of signature
OT name, signature, and date	Indicate the occupational therapist's name, signature, and date of signature
SLP name, signature, and date	Indicate the speech language pathologist's name, signature, and date of signature

Provider Information and Required Signature

Field Description	Guidelines
Provider name	Enter the provider's name
CSHCN TPI	Enter the provider's 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
Provider contact name	Enter the provider's contact name
Telephone number	Enter the provider's telephone number
Fax number	Enter the provider's fax number
Address/City/ZIP	Enter the provider's address, city, and ZIP
Provider signature	Provider must sign in this field
Date	Enter the date the form is signed

Additional Requirements

- The GP or the GO modifier is required when requesting prior authorization for PT and OT services. PT should be requested using the GP modifier and OT should be requested using the GO modifier.
- SLP services should be requested using the GN modifier.
- Time-based procedure codes are billed in units (15-minute increments).
- Untimed or encounter-based procedure codes are billed once per day.

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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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Please print or type requested information below.

Client Information

First name:	Last name:
CSHCN Services Program number: 9-_____-00	Date of birth:
Does the client receive therapy services through a school district?* ☐ Yes ☐ No	
* If "yes," please indicate in the evaluation how it is different than the services requested under CSHCN.	
Diagnosis Code(s):	

Evaluation Summary

Date of evaluation:	(A copy of the initial evaluation *must* be attached.)
Type of evaluation: ☐ Physical Therapy (PT) ☐ Occupational Therapy (OT) ☐ Speech Language Pathology (SLP)	
Comments:	

Service Request

Indicate procedure code(s), modifier, the dates of service, and the frequency per week or month. Dates of service cannot exceed six months. If possible, end requested date(s) of service on the last day of a month.

Procedure Code	Modifier	From Date	To Date	Frequency/Week	Frequency/Month

Physician name:	Physician signature:	Date:
PT name:	PT signature:	Date:
OT name:	OT signature:	Date:
SLP name:	SLP signature:	Date:

Provider Information and Required Signature

Provider name:	
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Provider contact name:	
Telephone number:	Fax number:
Address/City/ZIP:	
Signature of provider:	Date: