CRCP Prior Authorization Request Form

If any portion of this form is incomplete, it will be returned.

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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Type of Request	☐ **CRCP – CCP services** Fax request to 1-512-514-4212	☐ **CRCP services** Fax request to 1-512-514-4213

1. Client Information:

Client Name	First:	Last:	Middle Initial:
Medicaid Number (PCN):			Date of Birth:

2. Requested Service Details:

Primary Diagnosis:	Dates of Service	From:	To:

Procedure Code	Number of Visits	Frequency

Brief description of respiratory services and goals for services provided by the CRCP:

Note: S9441 services must be performed by a Certified Asthma Educator and documentation of certification must be submitted with the request. Respiratory therapy care services that do not require the specialty of a certified respiratory care practitioner are not a benefit.

3. Medical Necessity Information:

For CRCP-CCP services include the reason service/education needs to be provided in the home setting and cannot be provided in the office or facility setting.

For CRCP services document why the respiratory therapy visits included in the Home Health DME rental of a ventilator or the monthly respiratory therapy visit included in the Ventilator Service Agreement would not meet the client's medical needs.

4. Prescribing Physician Certifications: (*To be completed by the prescribing physician)*

By prescribing the CRCP services my signature below certifies the following:

For CRCP - CCP Services

Client has a history of more than one emergency room or acute care clinic visits within the last three months.

Requested service/education needs to be provided in the home setting and cannot be provided in the office or facility setting.

For CRCP Services

Client wishes to be cared for at home and has adequate social support services to be cared for at home.

Client is on a ventilator at least six hours per day.

Client has been ventilator dependent for 30 consecutive days or more as an inpatient.

Respiratory therapy services are in lieu of respiratory services requiring the client to remain in an inpatient care setting.

Signature of prescribing physician:		Date:
Printed or typed name of physician:		
Address/City/ZIP:		
Telephone number:	Fax Number:	
TPI:	NPI:	License Number:

5. Billing Provider Information: *(If different than the provider in Section 4)*

Provider printed name:			Date:
Contact person if Home Health agency:			
Address/City/ZIP:			
Telephone number:	Fax number:	TPI:	NPI: