THSteps Dental Mandatory Prior Authorization Request Form

If any portion of this form is incomplete and/or missing any required documentation, 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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Submit this form using TMHP's PA on the Portal. 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 Portal user name and password.	**This form may also be submitted by mail to:** **Texas Medicaid & Healthcare Partnership** **THSteps Dental Prior Authorization Unit** **PO Box 204206** **Austin TX 78720- 4206**

Client Name (Last, First, MI):

Medicaid Number (PCN):	**Date of Birth:**

☐ Restorative

☐ Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)

Note: *Check all documentation submitted for review with the prior authorization request.*

☐ Panorex	☐ FM X-ray	☐ Periapicals	☐ Photos	☐ Other Documentation

☐ Orthodontic Services

Note: *Check all documentation submitted for review with the prior authorization request.*

☐ Plaster cast models	☐ E-models	☐ HLD	☐ Panorex	☐ Cephalometric X-ray with tracing
☐ FM X-ray	☐ Photos	☐ Other Documentation (please specify):		

Date of Service Diagnostic Tools Were Produced:

Proposed Treatment Plan

Procedure Code	Tooth Number or Letter	Surface	Charge

Dentist's Certifications (to be completed by the performing dentist)

By checking the boxes below and signing this form:

☐ I certify all radiographs, photographs, and other documentation of medical necessity for the requested services are unaltered.

☐ I certify I have discussed all treatment options with the client and parent or legal guardian, including the recommended surgical treatment plan. I have addressed the client's risks if the treatment plan is not followed to completion and explained the treatment plan should not be started if the family does not agree to this course of treatment.

☐ I certify all primary dentition have been exfoliated (D8080).

I certify I have one of the following designations from the Texas Board of Dental Examiners, or I meet the continuing education requirements to provide orthodontic services:

☐ Board certified or board eligible pediatric dentist.

☐ Board certified or board eligible orthodontist.

☐ General dentist attesting to completion of a minimum of 200 continuing dental education hours in orthodontics, only 8 hours can be online or self-instruction.

Note: *Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services, but documentation must be produced by the dentist during retrospective review.*

Signature of performing dentist:		Date:	
Printed or typed name of dentist:		Dentist telephone:	
Address:		Fax:	
TPI:	NPI:	Taxonomy:	Benefit Code: