Home Telemonitoring Services
Prior Authorization Request Form Instructions

General Instructions

The prior authorization form must be completed and signed as outlined in the instructions below before it is submitted to TMHP.

To submit the form using PA on the Portal, visit tmhp.com and select **Prior Authorization** from the Topics drop-down menu. Select **PA on the Portal** from the left-hand menu and enter your TMHP Portal account username and password.

The prior authorization form may also be submitted as follows:

- By fax to the Texas Medicaid Special Medical Prior Authorization department at 512-514-4213
- By mail to the address specified on the prior authorization form

A copy of the signed and dated form must be maintained by the ordering physician in the client's medical record. The form is subject to retrospective review.

The home health agency, outpatient hospital, Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) may complete the following actions:

- Section A: Client information
- Section B: Requested home telemonitoring service information
- Section C: Authorization period
- Section D: Requesting provider information
- Section E: Rendering home telemonitoring provider information

Note: *Fields marked with an asterisk below indicate an essential or critical field. If these fields are not completed, your prior authorization request will be returned.*

Section A: Client information (completed by home health agency, outpatient hospital, FQHC, or RHC)

Enter the client's name, Medicaid number, and date of birth as indicated on the Texas Medicaid eligibility card or form.

First Name*: Jane	Last Name*: Doe	MI: M
Medicaid Number*: 123456789	Date of Birth*: 01/01/2021	

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Section B: Requested home telemonitoring service information (completed by home health agency, outpatient hospital, FQHC, or RHC)

All clients with diabetes and hypertension, regardless of their age, may qualify for home telemonitoring services when at least one risk factor is identified. Check at least one qualifying condition and at least one applicable risk factor.

Home telemonitoring qualifying conditions (Check at least one qualifying condition.): ☐ Diabetes ☐ Hypertension

Risk factors for clients with diabetes or hypertension (Check at least one risk factor. Check all that apply.):

☐ Two or more hospitalizations in the past 12-month period

☐ Frequent or recurrent admission to an emergency department

☐ Documented history of poor adherence to medication regimens

☐ Documented risk of falls

☐ Documented history of care access challenges

Clients 20 years of age or younger who are diagnosed with an end-stage solid organ disease, have received an organ transplant, or who require mechanical ventilation may also qualify for home telemonitoring services. Check a qualifying condition as applicable.

Additional home telemonitoring qualifying conditions for clients 20 years of age or younger:

☐ Mechanical ventilation ☐ End-stage solid organ disease ☐ Transplant

Section C: Authorization period (completed by home health agency, outpatient hospital, FQHC, or RHC)

Requests may be considered for a maximum period of 180 days. Requests for continuing home telemonitoring services that are received after the current prior authorization period ends will be denied for dates of service before the date that the request was received. Enter the dates of service, order frequency, and procedure code(s).

Requested start date*: 01/01/21	Requested end date*: 03/31/21
Procedure code(s)*:	
Requesting provider-ordered frequency of clinical data transmission*:	
Comments (optional):	

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Section D: Requesting provider information (must be completed by home health agency, outpatient hospital, FQHC, RHC, or provider requesting home telemonitoring services)

Enter the name and National Provider Identifier (NPI) of the Medicaid provider that is ordering the requested service. The requesting provider may sign and date the form or a prescription, written order, or verbal order. A nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) may complete and sign this section as a physician's delegate.

Requesting provider's name*: John Smith	NPI*: 111111111

The requesting provider's dated signature is required unless one of the following is attached to the request:

- Signed and dated prescription
- Dated written order
- Dated documented verbal order (may be on a plan of care or treatment plan)

Requesting provider's signature:	Date signed:

Section E: Rendering home telemonitoring provider information (completed by home health agency, outpatient hospital, FQHC, or RHC)

Enter the name, contact person, address, telephone, fax number, Tax ID, NPI, benefit code (when applicable), and taxonomy code of the Medicaid provider that will be providing the requested service or benefit.

Note: *This form is incomplete without the home telemonitoring provider's dated signature.*

Rendering provider's printed name*: John Smith		Contact person: Ann Joe
Street address*: 123 Street		
City: Somewhere	State: Texas	ZIP + 4*: 12345-1234
Telephone: 512-555-1234	Fax: 512-555-4321	
Tax ID: 98-7654321	NPI*: 1234567890	
Taxonomy*: 251X00000X	Benefit Code*:	
Rendering provider's signature:		Date signed: