CSHCN Services Program Prior Authorization Request for Diapers, Pull-ups, Briefs, or Liners Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Diapers, Pull-ups, Briefs, or Liners 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 are denied. Requests are considered only when completed and received before the service is provided.
- 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
12357-B Riata Trace Parkway Ste #100 MC-A11
Austin, TX 78727

- This form may be submitted by fax to 1-512-514-4222.
- Submit only the prior authorization form. Do not submit instruction pages.
- **Refer to:** Chapter 18, "Expendable Medical Supplies."
- This form is required if the client's medical need exceeds a combination of 240 diapers, pull-ups, briefs, or liners, or for clients who do not have a diagnosis listed in the CSHCN Services Program Provider Manual.
- Clients must be 4 years of age or older and be incontinent as a direct complication of a medical condition.

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
Diagnoses	Enter the diagnosis codes(s) relevant to the need for diapers, pull-ups, briefs, or liners

Product Information

Field Description	Guidelines
Product type	Check the appropriate product type
Quantity needed per month	Indicate the quantity needed per month (Exceeding the 240 limitation)
Procedure code	Indicate the procedure code
Document medical necessity for additional products	Document the medical necessity for additional products

Unlisted Diagnosis Information

Field Description	Guidelines
Indicate unlisted diagnosis	Enter the unlisted diagnosis
Document medical necessity for unlisted diagnosis	Document the medical necessity for an unlisted diagnosis

Vendor Information and Required Signature

Field Description	Guidelines
Vendor name	Enter the vendor’s name
CSHCN TPI	Enter the vendor’s Texas provider identifier (TPI)
NPI	Enter the vendor’s national provider identifier (NPI)
Taxonomy code	Enter the vendor’s taxonomy code
Benefit code	Enter DM3
Telephone number	Enter the vendor’s telephone number
Fax number	Enter the vendor’s fax number
Address/City/State/ZIP	Enter the vendor’s address, city, state, and ZIP
Signature	Vendor must sign in this field
Date	Enter the date the form is signed

Physician Information and Required Signature

Field Description	Guidelines
Physician name	Enter the physician’s name
Telephone number	Enter the physician’s telephone number
Fax number	Enter the physician’s fax number
Signature	Physician must sign in this field
Date	Enter the date the form is signed

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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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This form is required if the client's medical need exceeds a combination of 240 diapers, pull-ups, briefs, or liners, or for clients who do not have a diagnosis listed in the *CSHCN Services Program Provider Manual*.

Client Information:

First name:	Last name:
CSHCN Services Program number: 9-________________________-00	Date of birth:
Address/City/State/ZIP:	
Diagnoses:	

Product Information:

☐ Diapers	Quantity needed per month: ________________	Procedure Code: ______________________
☐ Pull-ups	Quantity needed per month: ________________	Procedure Code: ______________________
☐ Briefs	Quantity needed per month: ________________	Procedure Code: ______________________
☐ Liners	Quantity needed per month: ________________	Procedure Code: ______________________
Document medical necessity for additional products:		

Unlisted Diagnosis Information:

Indicate unlisted diagnosis:
Document medical necessity for unlisted diagnosis:

Vendor Information and Required Signature:

Vendor name:	Vendor contact name:
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code:
Telephone number:	Fax number:
Address/City/State/ZIP:	
Signature:	Date:

Physician Information and Required Signature:

Physician name (printed or typed):	Physician contact name:
Telephone number:	Fax number:
Signature:	Date: