CSHCN Services Program Prior Authorization Request for Diabetic Equipment and Supplies Form

General Information

- Ensure the most recent version of the Prior Authorization Request for Diabetic Equipment and Supplies 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 15, "Diabetic Equipment and Supplies" 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
Address/City/State/ZIP	Enter the client's address, city, state, and ZIP
Diagnoses	Enter the diagnosis code(s) relevant to the diabetic equipment and supplies

Statement of Medical Necessity

Field Description	Guidelines
HCPCS Code / Service Description	Check the appropriate procedure code being requested
Most recent Hb/A1C results?	Indicate the most recent Hb/A1 C results
Date	Indicate the date of the most recent Hb/A1C results
Check applicable boxes	Check the applicable box

Provider Information and Required Signature

Field Description	Guidelines
Provider name	Enter the provider's name
Contact person	Enter the contact person
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
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

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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

CSHCN Services Program Prior Authorization Request for Diabetic Equipment and Supplies Form

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

Statement of Medical Necessity		
HCPCS Code	**Service Description**	**Quantity/Frequency**

Most recent Hb/A1C results? (*Please attach recent history of glucose levels*.)	Date of most recent Hb/A1C results:

FOR RENTAL OF THE EXTERNAL INSULIN PUMP:

For clients diagnosed with Type 1 or Type 2 diabetes, please attach the supporting clinical documentation and indicate at least two of the following conditions that apply:

- ☐ Initial rental for three months
- ☐ Elevated glycosylated hemoglobin level (HbA1c) > 7.0%
- ☐ History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
- ☐ History of severe glycemic excursions with wide fluctuations in blood glucose
- ☐ History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness

By signing this form, the prescribing provider attests

that : The client and or caregiver possess the following:

- The cognitive and physical abilities to use the recommended insulin pump treatment regimen.
- The willingness to support the use of the external insulin pump.

Prior to the initiation of pump therapy:

- A training/education plan will be completed.
- The client and/or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating insulin pump therapy with their current treatment regimen for ambient glucose control.

FOR PURCHASE OF THE EXTERNAL INSULIN PUMP:

An external insulin pump may be considered for prior authorization of purchase after it has been rented for a 3-month trial and all of the following documentation is provided:

- ☐ Three-month trial successfully completed
- ☐ The training/education plan has been completed
- ☐ The pump is the appropriate equipment for the specific client
- ☐ The client is compliant with the use of the pump

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HCPCS Code	Service Description	Quantity/Frequency

Most recent Hb/A1C results? (Please attach recent history of glucose levels.)	Date of the most recent Hb/A1C results:

FOR CONTINIOUS GLUCOSE MONITOR DEVICE AND SUPPLIES:

Available for clients diagnosed with Type 1 diabetes ONLY. Please attach the supporting clinical documentation and indicate at least two of the following conditions that apply:

- ☐ Elevated glycosylated hemoglobin level (HbA1c) > 7.0%
- ☐ History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
- ☐ History of severe glycemic excursions with wide fluctuations in blood glucose
- ☐ History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness
- ☐ History of diabetic ketoacidosis

By signing this form, the prescribing provider attests that: The client and or caregiver possess the following:

- The cognitive and physical abilities to use the recommended continuous glucose monitor regimen.
- An understanding of cause and effect.
- The ability to learn to use the device, and to hear and view alerts and respond appropriately
- The willingness to support the use of the continuous glucose monitor (CGM).

Prior to the initiation of continuous glucose monitor therapy:

- A training/education plan will be completed.
- The client and/or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating continuous glucose monitor therapy with their current treatment regimen for ambient glucose control.

Client Information

First name:	Last name:
CSHCN Services Program number: 9-_____-00	Date of birth:

Provider Information and Required Signature

Provider name (type or print):	Contact person:
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Telephone number:	Fax number:
Address/City/ZIP:	
Provider signature:	Date: