CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Inpatient Surgery—For Surgeons Only 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 24, "Hospital."

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
Diagnosis	Enter the diagnosis code relevant to the need for inpatient surgery.

Procedure Information

Field Description	Guidelines
Surgical procedure(s) requested	Enter the surgical procedure(s) being requested (per CPT code)
Benefit code	Enter the CSN benefit code
Anticipated date of surgery	Enter the anticipated date of surgery
Facility name	Enter the facility's name
Facility CSHCN TPI	Enter the facility's CSHCN TPI
Facility NPI	Enter the facility's NPI
Facility taxonomy code	Enter the facility's taxonomy code
Benefit code	Enter the CSN benefit code

Field Description	Guidelines
Other insurance information (check each that applies)	Enter the client's other insurance type (private, Medicare, or Medicaid)
Insurance type/carrier	Enter the insurance type/carrier
Insurance ID number	Enter the insurance ID number

Surgeon's Information and Required Signature

Field Description	Guidelines
Surgeon's name	Enter the surgeon's name
Surgeon's contact name	Enter the surgeon's contact name
Surgeon's CSHCN TPI	Enter the surgeon's CSHCN Texas provider identifier (TPI)
Surgeon's NPI	Enter the surgeon's national provider identifier (NPI)
Surgeon's taxonomy code	Enter the surgeon's taxonomy code
Benefit Code	Enter the CSN benefit code
Telephone number	Enter the surgeon's telephone number
Fax number	Enter the surgeon's fax number
Address/City/State/ZIP	Enter the surgeon's address, city, state, and ZIP
Surgeon signature	Surgeon must sign in this field
Date	Enter the date the form is signed

Additional Requirements

Prior Authorization request for inpatient surgery services:

- The admitting facility must obtain prior authorization for an inpatient stay using the CSHCN Services program Prior Authorization Request for Inpatient Hospital Admission (for facility only) form.
- Some surgical procedures have specialty team requirements.
- Providers must include additional information as applicable (documentation for procedures, medical necessity, etc.).
- For rhizotomy and craniotomy for anterior temporal lobectomy see the CSHCN Services Program Provider Manual for specific criteria that must accompany the request for any of these procedures.

CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only

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 Inpatient Surgery—For Surgeons Only

Client Information:		
First name:	Last name:	
CSHCN Services Program number: 9-_____-00	Date of birth:	
Address/City/State/ZIP:		
Diagnosis:		
Procedure Information:		
Surgical procedure(s) requested (per CPT code):		
Anticipated date of surgery:		
Facility name:		
Facility CSHCN TPI:	Facility NPI:	
Facility taxonomy code:	Benefit code: **CSN**	
Other insurance information (check *each* that applies)	☐ No ☐ Yes	If Yes: ☐ Private ☐ Medicare ☐ Medicaid
Insurance Type/Carrier:	Insurance ID number:	
Surgeon's Information and Required Signature:		
Surgeon's name:	Surgeon's contact name (if any):	
Surgeon's CSHCN TPI:	Surgeon's NPI:	
Surgeon's taxonomy code:	Benefit code: **CSN**	
Telephone number:	Fax number:	
Address/City/State/ZIP:		
Surgeon signature:		Date: