CSHCN Services Program Prior Authorization Request for Medical Foods Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Medical Foods 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 26, "Medical Nutrition Services," in the current *CSHCN Services Program Provider Manual*.
- This form is not for formula products. For formula products, use the CSHCN Services Program Prior Authorization Request for Additional Nutritional Assessment, Counseling, and Products form.

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 need of medical foods

Requested Services

Field Description	Guidelines
Name of product	Indicate the type of requested product
Indicate the reason for the requested product	Place a check mark in the appropriate box and provide a written specification when applicable

Medical Necessity Information

Field Description	Guidelines
Medical necessity information	Document the medical necessity for the requested product

Medical Foods Provider Information

Field Description	Guidelines
Medical foods provider name	Enter the medical foods provider's name
Contact person	Enter the contact name
CSHCN TPI	Enter the medical foods provider's CSHCN Texas provider identifier (TPI)

Field Description	Guidelines
NPI	Enter the medical foods provider's national provider identifier (NPI)
Taxonomy code	Enter the medical foods provider's taxonomy code
Benefit code	Enter the CSN benefit code
Telephone number	Enter the medical foods provider's telephone number
Fax number	Enter the medical foods provider's fax number
Address/City/State/ZIP	Enter the medical foods provider's address, city, state, and ZIP

Physician Information and Required Signature

Field Description	Guidelines
Physician name	Enter the physician name
CSHCN TPI	Enter the physician CSHCN TPI
NPI	Enter the physician NPI
Taxonomy code	Enter the physician taxonomy code
Benefit code	Enter the CSN benefit code
Telephone number	Enter the physician telephone number
Fax number	Enter the physician fax number
Address/City/State/ZIP	Enter the physician address, city, state, and ZIP
Physician signature	Physician must sign in this field
Date	Enter the date the form is signed

Additional Requirements

Prior Authorization request for medical foods:

- Prior authorization is not required if the client has one of the diagnosis codes listed in the CSHCN Services Program Provider Manual Medical Nutrition Services section.
- Prior authorization and documentation of medical necessity is required for all other diagnoses, new products, or products not listed as approved.

CSHCN Services Program Prior Authorization Request for Medical Foods

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 Medical Foods

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

Requested Services:	
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Name of product:	
Indicate the reason for the requested product:	
☐ Diagnosis: _____	☐ New product
☐ Other: _____	☐ Product not listed

Medical Necessity Information (attach additional Information if needed)

Medical Foods Provider Information:	
Medical foods provider name:	Contact person:
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Telephone number:	Fax number:
Address/City/State/ZIP:	

Physician Information and Required Signature:	
Physician name:	Contact person:
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Telephone number:	Fax number:
Address/City/State/ZIP:	
Physician signature:	Date: