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

General Information

- Ensure the most recent version of the Prior Authorization Request for Medical Nutritional Services 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 25, "Medical Nutrition Services" 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 need for additional nutritional assessment, counseling, and products

Nutritional Counseling and Assessment, Reassessments, and Intervention Information

Field Description	Guidelines
More than 1 hour (4 units) of nutrition assessments and interventions or more than 3 hours (12 units) of reassessments and intervention per rolling year	Check this item when requesting more than 1 hour (4 units) of nutrition assessments and interventions or more than 3 hours (12 units) of reassessment and intervention per rolling year
More than 4 nutritional counseling visits per rolling year	Check this item when requesting more than four nutritional counseling visits per rolling year
Document medical necessity for additional nutritional assessments, or reassessments and intervention, and counseling below:	Document medical necessity

Dietician Information and Required Signature for Additional Medical Nutritional Counseling

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

Nutritional Products

Field Description	Guidelines
Name of product	Enter the name of the nutritional product that is listed on the product label
Size of can	Enter the size of can
Procedure Code	Enter the procedure code for the nutritional product being requested
Number of cans	Indicate the number of cans
Is part or all nutritional intake via tube	Indicate whether none, part, or all nutritional intake is via tube
Document medical necessity, including prescribed caloric intake	Document medical necessity for nutritional products. Provide the client's current height and weight and attach the client's growth charts.

Prescribing Physician Information and Required Signature

Field Description	Guidelines
Physician's name	Enter the name of the physician prescribing the nutritional product
Telephone number	Enter the prescribing physician's telephone number
Fax number	Enter the prescribing physician's fax number
Signature	Prescribing physician must sign in this field
Date	Enter the date the form is signed

Dispensing Provider Information

Field Description	Guidelines
Provider name	Enter the name of the provider dispensing the medical nutritional product
Telephone number	Enter the dispensing provider's telephone number
Fax number	Enter the dispensing provider's fax number
CSHCN TPI	Enter the dispensing provider's CSHCN Texas provider identifier (TPI)
NPI	Enter the dispensing provider's national provider identifier (NPI)

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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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Client Information

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

Nutritional Counseling and Assessment, Reassessments, and Intervention Information: Check the appropriate box

☐ More than 1 hour (4 units) of nutrition assessments and interventions or more than 3 hours (12 units) of reassessments and intervention per rolling year	☐ More than 4 nutritional counseling visits per rolling year
Document medical necessity:	

Dietician Information and Required Signature for Additional Medical Nutritional Counseling

Dietician name:	
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Telephone number:	Fax number:
Address/City/State/ZIP:	
Is part or all nutritional intake via tube? ☐ None ☐ Part ☐ All	
Prescribing physician signature:	Date:

Nutritional Products

Name of product:	Procedure code:
Size of can:	Number of cans:
Is part or all nutritional intake via tube? ☐ None ☐ Part ☐ All	
Document medical necessity, including prescribed caloric intake, current height and weight, and attach growth charts:	

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Prescribing Physician Information and Required Signature	
Prescribing physician name (printed or typed):	
Contact name:	
Telephone number:	Fax number:
Prescribing physician signature:	Date:

Client Information	
First name:	Last name:
CSHCN Services Program number: 9-___________________-00	

Dispensing Provider Information	
Provider name (printed or typed):	
Telephone number:	Fax number:
CSHCN TPI:	NPI: