CSHCN Services Program Prior Authorization Request for Renal Dialysis Treatment Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Renal Dialysis Treatment 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 34, "Renal Dialysis," 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 renal dialysis treatment

Procedure Information

Field Description	Guidelines
Date of first dialysis treatment	Enter the date of the first dialysis treatment being requested
Type of treatment	Check the appropriate type of treatment box

Medicare Information

Field Description	Guidelines
Is the client eligible for Medicare?	Check the appropriate box
Has the client applied for Medicare?	Check the appropriate box
If yes, date applied	Enter the date the client applied for Medicare
Date Medicare approved or denied	Enter the date Medicare approved or denied eligibility (if denied, attach copies of the denial letters from Medicare on this form)

Dialysis Center Information and Required Signature

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

Additional Requirements

Prior authorization request for renal dialysis treatment:

- An initial prior authorization of three months will be given to clients seeking eligibility under Medicare. An additional three months may be prior authorized on a case-by-case basis if clients have applied for, but not yet received, a determination from Medicare at the end of the initial authorization.
- If a denial for Medicare is received, or if the referring provider attests that the client is ineligible for Medicare, an open-ended prior authorization may be granted.

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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 Renal Dialysis Treatment

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

Procedure Information	
Date of first dialysis treatment being requested: _____	
☐ 821 Hemodialysis	☐ 845 CAPD support services method II
☐ 841 Continuous ambulatory peritoneal dialysis (CAPD) method I	☐ 855 CCPD support services method II
☐ 851 Continuous cycling peritoneal dialysis (CCPD) method I	

Medicare Information	
Is the patient eligible for Medicare?	☐ Yes ☐ No
Has patient applied for Medicare? ☐ Yes ☐ No	If Yes, date applied: Medicare:_____
Date Medicare approved or denied: _____ (*If denied, attach copies of denial letters from Medicare to this form*).	

Dialysis Center Information and Required Signature	
Center name:	Center contact name (if any):
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Telephone number:	Fax number:
Address/City/State/ZIP:	
Authorized signature:	Date: