Psychiatric Inpatient Extended Stay Request Form

This form can be submitted to TMHP using the TMHP **PA on the Portal** (click "PA on the Portal" and enter your TMHP portal account username and password). This form can also be submitted by fax to **1-512-514-4211**, or by mail to:

Texas Medicaid & Healthcare Partnership
Attn: **TMHP-CCIP**
12357-B Riata Trace Parkway, Suite 100
Austin, Texas 78727-6422

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 *Texas Medicaid Provider Procedures Manual* (TMPPM).

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 Medicaid enrollment and/or personal exclusion from Texas Medicaid.

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 relevant *Texas Medicaid Provider Procedures 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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A. Client Information			
Client Name (*Last, First, M.I.*):			
Medicaid Number:			Date of Birth:
Age:	Sex:	Date of Admission:	Date Submitted:

B. Facility Information			
Name:		Contact Person:	
Telephone:		Fax:	
Address (Street/City/State/ZIP):			
TPI:	NPI:	Taxonomy:	Benefit Code:
Commitment Type (*if applicable*):	Effective Date:	Judge:	Ordering County:

Referral Source: ☐ Admitting MD ☐ MH Professional ☐ Other (list):

Current Living Arrangements: ☐ With parent(s) ☐ Group/foster home ☐ Independent Living ☐ Other (list):

C. Primary symptoms that required admission and current status requiring extended inpatient care (Provide detail as to dates of occurrence, frequency, duration, and severity as applicable)

D. Other relevant clinical/diagnostic information about the patient from the past 72 hours, including inability to be treated in less restrictive setting (Attach additional pages or documents, as necessary)

E. Present and Past Drug/Alcohol Usage

Name	Current Use?

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F. Current Psychiatric Medication (include total daily doses)

G. Past Psychiatric Treatment

Number of previous inpatient admissions:	Dates of most recent inpatient stay: to:

Previous outpatient treatment (provider or facility, frequency). If none, why?

H. Discharge Criteria

I. Describe Treatment, Contacts, Plans (including outcome) with Family, School, etc.

J. Current DSM Diagnoses

K. No. of Hospital Days Requested

[ ] Dates From: To:	**Projected Discharge Date** (*required*):

L. Aftercare Plan

Provider or Facility:

Frequency:

M. Provider Information

Provider Name (*please print*):

Telephone No.:	Fax No.:

Address (Street/City/State/ZIP):

TPI:	NPI:	License No.:

Provider Signature *(stamped signatures not accepted)*	Date