

Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests have to be scanned and data entered before the PA Department receives them, which takes up to 24 hours. To access PA on the Portal, go to www.tmhp.com, click on "Providers," then "Prior Authorization" from the left hand menu. Then click "PA on the Portal" from the left hand menu and enter your TMHP Portal account user name and password. To submit by fax, send to 1-512-514-4212.

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

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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Section A: Client and Provider Information (May be completed by provider)					
Client Information					
Client Name:		Medicaid Number:		Date of Birth:	
Physician Information					
Name:		Telephone:		Fax number:	
License Number:		TPI:		NPI:	
Supplier Information					
Name:		Telephone:		Fax number:	
Address (Street, City, State, ZIP):					
TPI:		NPI:		Taxonomy:	
<i>I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.</i>					
Supplier Representative's Printed Name:					
Supplier Representative's Signature:				Date Signed:	
Section B: Oxygen Therapy Request (Must be completed by physician)					
Type of request: <input type="checkbox"/> Initial Request <input type="checkbox"/> Renewal Request					
HCPCS Code	Description of DME Requested	Qty.	Price	Diagnosis	Brief Diagnosis Description
Note: The "Duration of need for DME" and "Date client last seen last seen by physician," below <u>must</u> be filled in.					
Duration of need for DME: _____ month(s)			Date client last seen by physician:		
Documentation of Medical Necessity					
Date of testing:		Arterial pO ₂ (mm HG):		Oxygen Saturation:	
Lowest Oxygen Saturation at rest or with exercise (percent):			or Arterial pO ₂ (mm Hg):		
Lowest Oxygen Saturation during sleep (percent):			or Arterial pO ₂ (mm Hg):		
For pO ₂ of 56-59 mm Hg or oxygen saturation 89% or higher (for initial requests only):					
<input type="checkbox"/> Dependent edema <input type="checkbox"/> Cor pulmonale <input type="checkbox"/> Erythrocythemia (include hematocrit):					
For cluster headaches, enter the date of neurological examination (for initial requests only):					
Documentation of failed medication therapy (for initial requests only):					
Flow rate (l/min.):			Hours of treatment per day (estimated):		
Is oxygen therapy required for use within the home?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is oxygen therapy required for traveling when leaving the home?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Client is compliant with oxygen usage as ordered in initial request (for renewal requests only):				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician Signature					
<i>If requesting supplies only, I certify that the client owns his or her oxygen therapy device.</i>					
Prescribing Physician's Signature:				Date Signed:	