Case Management for Children and Pregnant Women (CPW)
Initial Prior Authorization Request

Instructions for completing the CPW Initial Prior Authorization Request form are provided below. Field names marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.

Instructions	
Prior Authorization Submitter Certification Statement	
We Agree	Read the entire Prior Authorization Submitter Certification Statement and check "We Agree".
Section A: Client Information	
Client Last Name *	Enter the client's last name as indicated on the Texas Medicaid eligibility card or form.
Client First Name *	Enter the client's first name as indicated on the Texas Medicaid eligibility card or form.
Medicaid Number *	Enter the client's Medicaid 9-digit identification number as indicated on the Texas Medicaid eligibility card or form.
Date of Birth *	Enter the client's date of birth as indicated on the Texas Medicaid eligibility card or form.
Gender	Select the client's gender.
Language Preference	Enter the client's language preference.
Parent/Guardian	Enter the client's parent/guardian name.
Home Phone	Enter the client's phone number.
Alternate Phone	Enter an alternate phone number for the client.
Mailing Address	Enter the client's mailing address.
City	Enter the client's city.
State	Enter the client's state.
ZIP	Enter the client's ZIP Code.
PCP	Enter the name of the client's primary care physician.
Referral Date	Enter the date the client was referred to CPW.
Referral Source Agency	Enter the name of the referral source agency.
Name of Contact	Enter the name of the contact at the referral source agency.
Phone	Enter the phone number of the referral source agency.

* Essential/Critical field

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Instructions	
Section B: Clinician Information	
Health Condition, Health Risk, or High-Risk Condition	Document health conditions or describe specific health risks, symptoms, developmental delays, and behaviors. Describe how the health condition, health risk, symptoms, developmental delays, and behaviors impact level of functioning. For a pregnant woman, describe the high-risk condition and how the condition impacts level of functioning.
Psychosocial Factor	Describe any specific high-risk psychosocial factors that impact the health condition, health risk, or high-risk condition.
Client Is a: Child (age 0–20) with a health condition or health risk. Pregnant woman (of any age) with a high-risk condition.	Select the appropriate category.
Expected Date of Delivery	Enter the expected date of delivery.
Specific Needs Related to the Health Condition, Health Risk, or High-Risk Condition	In each box, describe one specific need and intervention. List and describe any barriers or problems related to accessing the specific need. (Document up to three specific needs.)
Section C: Requested Service	
HCPCS Code *	HCPCS procedure code G9012 is to be used for all comprehensive and follow-up visits.
Quantity *	Enter the number of visits requested.
From Date of Service *	Enter the date the services are initiated.
To Date of Service *	Enter the last date the services are requested.
Modifier *	Enter the appropriate modifier: **TS** Follow-up service **U2** Comprehensive visit

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Instructions	
Section D: Submission Information	
Signature of the Person Completing the Form	Have the person completing the form sign here.
Printed Name of the Person Completing the Form	Enter the printed name of the person completing the form here.
Requesting Case Manager Name *	Enter the name of the requesting case manager.
Requesting Case Manager NPI (Blank if FQHC) *	Enter the NPI number of the requesting case manager (this can be blank for an FQHC).
Taxonomy Code *	Enter the taxonomy code of the requesting case manager.
Benefit Code *	Enter the benefit code of the requesting case manager.
Street Address *	Enter the street address of the requesting case manager.
City	Enter the city of the requesting case manager.
State	Enter the state of the requesting case manager.
ZIP *	Enter the ZIP Code of the requesting case manager.
Requesting Case Manager Signature (Stamped Signatures Not Accepted)	The requesting case manager should sign here.
Date Intake Completed *	Enter the date the intake was completed by the case manager.
Section E: Rendering Provider Information (This section is for the provider or agency that is billing for the services.)	
Rendering Provider (Complete Name of Group) *	Enter the name of the rendering provider (the group or individual being reimbursed for the services).
Rendering Provider NPI (Group or FQHC) *	Enter the NPI number of the rendering provider.
Taxonomy Code *	Enter the taxonomy code of the rendering provider.
Benefit Code *	Enter the benefit code of the rendering provider.
Rendering Provider Phone Number	Enter the phone number of the rendering provider.
Rendering Provider Fax Number	Enter the fax number of the rendering provider.
Street Address *	Enter the street address of the rendering provider.
City	Enter the city of the rendering provider.
State	Enter the state of the rendering provider.
ZIP *	Enter the ZIP Code of the rendering provider.

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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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Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

Section A. Client Information

Client Last Name*:		Client First Name*:
Medicaid Number*:		Date of Birth*:
☐ Male ☐ Female	Language Preference:	
Parent/Guardian:	Home Phone:	Alternate Phone:
Mailing Address:		
City:	State:	ZIP:
PCP:		Referral Date:
Referral Source: Agency:	Name of Contact:	Phone:

Section B. Clinical Information

Health condition, health risk, or high-risk condition:
Document health conditions or describe specific health risks, symptoms, developmental delays, and behaviors. Additionally, describe how the health condition, health risk, symptoms, developmental delays, and behaviors impact level of functioning. For a pregnant woman, describe the high-risk condition and how the high-risk condition impacts level of functioning.

Psychosocial factor:
If indicated, describe any specific high-risk psychosocial factors that are impacting the health condition, health risk, or high-risk condition.

The client is a:

☐ Child (age 0-20) with a health condition or health risk

☐ Pregnant woman (of any age) with a high-risk condition Expected date of delivery:

Specific needs related to the health condition, health risk, or high-risk condition:
In each box, describe one specific need and intervention. If indicated, list and describe any barriers or problems related to accessing the specific need. (Document up to three specific needs.)

* Essential/Critical field

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Section C. Requested Services

HCPCS Code*:	Quantity*:	From Date of Service*:	To Date of Service*:	Modifier*

Section D. Submission Information

By completing and submitting this request:

- I attest that the client/parent/guardian has confirmed the documented needs, was informed of the choice of case management providers, and desires case management services.
- I confirm that the information is true and correct to the best of my knowledge.
- I understand that prior authorization is a condition of reimbursement for services and not a guarantee of payment.

Signature of person completing form:	Printed name of person completing form:

Requesting Case Manager Name*:		
Requesting Case Manager NPI (Blank if FQHC)*:	Taxonomy*:	Benefit Code*:
Street Address*:		
City:	State:	ZIP*:
Requesting Case Manager Signature *(stamped signatures not accepted):*		Date intake completed*:

Section E. Rendering Provider Information

Rendering Provider (complete name of group)*:		
Rendering Provider NPI (group or FQHC)*:	Taxonomy*:	Benefit Code*:
Rendering Provider Phone Number:	Rendering Provider Fax Number:	
Street Address*:		
City:	State:	ZIP*:

Note: *Program staff may request additional information to support request.*

* Essential/Critical field