

Home Telemonitoring Services Prior Authorization Request Form Instructions

General Instructions

The prior authorization (PA) form must be completed and signed as outlined in the instructions below before it is submitted to TMHP.

To submit the form using 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 Portal user name and password.

The PA form may also be submitted by fax to the Texas Medicaid Special Medical Prior Authorization department at 512-514-4213, or by mail to the address specified on the PA form.

A copy of the signed and dated form must be maintained by the ordering physician in the client’s medical record. The form is subject to retrospective review.

The home health agency or outpatient hospital may complete the following actions:

Section A: Client Information

Section B: Requested telemonitoring service information

Section C: Authorization period

Section D: Requesting physician information

Section E: Rendering telemonitoring provider information

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 (completed by home health agency or outpatient hospital)

Enter the client’s name, Medicaid number, and date of birth as indicated on the Texas Medicaid eligibility card or form.

First Name*: Jane	Last Name*: Doe	MI: M
Medicaid Number*: 987654321	Date of Birth*: 01/01/2021	

Section B: Requested telemonitoring service information (completed by home health agency or outpatient hospital)

All clients regardless of age may qualify for telemonitoring services with conditions of diabetes or hypertension when two or more risk factors are identified. Check a qualifying condition and at least two applicable risk factors.

Home telemonitoring qualifying conditions	Diabetes	Hypertension
Risk factor for clients with diabetes or hypertension (check all that apply)		
Two or more hospitalizations in the prior 12-month period		
Frequent or recurrent emergency department admissions		
Documented history of poor adherence to medication regimens		
Documented history of falls in the prior six-month period		

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Limited or absent informal support systems
Living alone or being home alone for extended periods of time
Documented history of care access challenges

Clients 20 years of age and younger who are diagnosed with an end-stage solid organ disease, have received an organ transplant, or who require mechanical ventilation may also qualify for telemonitoring services. Check a qualifying condition as applicable.

Additional home telemonitoring qualifying conditions for clients 20 years of age or younger:

Mechanical ventilation End-stage solid organ disease Transplant

Section C: Authorization period (completed by home health agency or outpatient hospital)

Requests may be considered for a maximum period of 180 days. Requests for continuing telemonitoring services received after the current prior authorization period ends will be denied for dates of service provided before the date the request was received. Enter the dates of service, order frequency, and procedure code(s).

Requested start date*: 01/01/21	Requested end date*: 03/31/21
Procedure code(s)*:	
Physician-ordered frequency of clinical data transmission*:	
Comments (optional):	

Section D: Requesting physician information (must be completed by home health agency, outpatient hospital, or physician requesting home telemonitoring)

Enter the name and NPI of the Medicaid provider ordering the requested service. The requesting physician may sign and date the form or a prescription, written order, or verbal order. A registered nurse (RN), nurse practitioner (NP), clinical nurse specialist (CNS) or physician assistant (PA) may complete and sign this section as a physician's delegate.

Requesting physician's name*: John Smith	NPI*: 7654321-02
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Physician's dated signature is required unless one of the following from the physician is attached to the request:

- Signed and dated prescription
- Dated written order
- Dated documented verbal order (may be on a plan of care treatment plan)

Physician's signature	Date signed:
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Section E: Rendering telemonitoring provider information (completed by home health agency or outpatient hospital)

Enter the name, contact person, address, telephone, fax number, Tax ID, NPI, benefit code and taxonomy code of the Medicaid provider who will be providing the requested service or benefit. Without the telemonitoring provider's dated signature, the form is incomplete.

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Rendering provider printed name*: John Smith		Contact person: Ann Joe	
Street address*: 123 Street			
City: Somewhere		State: Texas	ZIP + 4*: 12345-1234
Telephone: 512-555-1234		Fax: 512-555-4321	
Tax ID*: 98-7654321		NPI*: 1234567890	
Taxonomy*: 7654321-02		Benefit Code*: 1234567891	
Rendering provider's signature:			Date signed: