

Medicaid Certificate of Medical Necessity for Reduction Mammoplasty

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 must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. To submit by fax, send to **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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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: To be completed by the requesting physician or physician staff			
Client Information			
Name*:	Medicaid number*:		
Height:	Weight:	Date of birth*:	
Breast size (must include photograph):			
Requesting Physician Information			
Name*:	Telephone:	Fax:	
Street address*:			
City:	State:	ZIP + 4*:	
Medical license number:	Tax ID*:	NPI*:	
Taxonomy*:	Benefit Code*:		
Section B: To be completed by the requesting physician			
Client has evidence of a restrictive pulmonary defect (provide results of pulmonary function studies in narrative section).	Yes	No	
Client has evidence of severe neck and back pain (provide results of therapies tried in narrative section).	Yes	No	
Client has evidence of ulnar paresthesia from thoracic nerve root compression (provide results of therapies tried in narrative section).	Yes	No	
Client has evidence of ischemic heart disease (provide results of abnormal EKG and/or coronary angiography).	Yes	No	
This client, if age 40 or over, has had a mammogram within the past year that was negative for cancer.	Yes	No	
Estimated the grams of breast tissue to be removed from each breast.	Right:	Left:	
The client is in a weight reduction program and has lost _____ lbs.	Yes	No	
Section C: Physician requesting reduction mammoplasty must complete narrative information regarding the medical necessity as requested above.			
Narrative note for medical necessity (write legibly):			
Requesting physician signature:	Date:		
Refer to the Reduction Mammoplasty policy in the <i>Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook</i> (Vol. 2, Provider Handbooks) of the current <i>Texas Medicaid Provider Procedures Manual</i> .			

* Essential/Critical field