Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-emergency Ambulance Exception

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 **512-514-4205**.

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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Submit completed form by fax to **512-514-4205.**

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.*

Requesting/Provider Information		
Requesting Provider Name*:		
Requesting Provider NPI*:	Date Request Submitted:	
Contact Name:	Telephone:	Fax:

Rendering Provider Information		
Rendering Ambulance Provider*:		Ambulance NPI*:
Tax ID*:	Benefit Code*:	Taxonomy*:
Street Address*:		
City:	State:	ZIP + 4*:

Client Information	
Client Name (*Last, First, MI*)*:	
Client Medicaid/CSHCN Number*:	Date of Birth*:
Functional, physical or mental health debilitating condition affecting transport:	

Requested Services	
HCPCS Procedure Code*:	**Brief Description of Services:**

* Essential/Critical field

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Request Type

By checking the boxes below and signing this form:

☐ I attest that the client has a permanent debilitating condition resulting in a physical or mental inability to perform activities for the remainder of his/her life. For this condition I am requesting a 180 day prior authorization request.

Additional information:

☐ I attest that the client has a debilitating condition resulting in a physical or mental inability to perform activities that can be expected to last for a continuous period of no less than 12 months. For this condition I am requesting a 180 day prior authorization request.

Additional information:

Documentation

The following attachments must be submitted with the request:

1. Nonemergency Ambulance Prior Authorization Request
2. Documentation supporting client's debilitating condition such as, but not limited to:
   - Discharge summary
   - Diagnostic image(s) interpretation report(s) (i.e., MRI, CT, X-rays)
   - Care plan

Note: *Documentation submitted with statements reading "client has a debilitating condition" is insufficient.*

Certification

I certify the information supplied in this document is true, accurate, complete, and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law which can result in fines or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.

Requesting Physician's Printed Name*:	Requesting Physician's NPI*:
Requesting Physicians' Signature:	Date Signed:

* Essential/Critical field

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Provider Instructions for Non-emergency Ambulance Exception

This form must be completed by the provider requesting a non-emergency ambulance exception. All non-emergency ambulance exception requests must have the physician document that the client has a debilitating condition and require recurring trips that will extend longer than 60 days.

1. **Requesting Provider Information**—Enter the name of the entity requesting authorization. (i.e., hospital, nursing facility, dialysis facility, physician).
2. **Request Date**—Enter the date the form is submitted.
3. **Requesting Provider Identifiers**—Enter the following information for the requesting provider (facility or physician):
   - Enter the requesting provider's name.
   - Enter the National Provider Identifier (NPI) number. An NPI is a ten-digit number issued by the National Plan and Provider Enumeration System (NPPES).
4. **Ambulance Provider Identifiers**—Enter the following information for the rendering ambulance provider:
   - Enter the rendering ambulance provider's name.
   - Enter the rendering ambulance provider's NPI.
   - Enter the rendering ambulance provider's Tax ID.
   - Enter the rendering ambulance provider's Benefit Code.
   - Enter the requested ambulance provider's primary national taxonomy code. This is a ten-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com.
   - Enter the requested ambulance provider's address.
5. **Client Information**—This section must be filled out to indicate the client's name in the proper order (last, first, middle initial). Enter the client's date of birth and client number.
6. **Requested Services**—Enter the requested Healthcare Common Procedure Coding System (HCPCS) procedure code and a brief description of the requested services. The applicable codes are listed below:

Procedure Codes			
A0382	A0398	A0422	A0424
A0425	A0426	A0428	A0430
A0431	A0433	A0434	A0435
A0436	A0999		

7. **Request Type**—Check the box for the request type. In the first box the physician is attesting that the client has a permanent debilitating condition. In the second box the physician is attesting that the client has a debilitating condition which is expected to last for a continuous period of no less than 12 months. The physician may provide additional information if needed.

8. **Documentation**—The provider must submit the completed Nonemergency Ambulance Exception form, the Nonemergency Ambulance Prior Authorization Request form and documentation supporting client's debilitating condition.(i.e. surgical report, summary of history, physical therapy evaluation summary).
9. **Physician Signature**—The request must be signed and dated by a physician. Stamped or computerized signatures and dates are not accepted. Without a physician's signature, NPI number provided and date, the form is considered incomplete. The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.