CSHCN Services Program Prior Authorization Request for Respiratory Care—Certified Respiratory Care Practitioners (CRCP) Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Respiratory Care—Certified Respiratory Care Practitioners (CRCP) form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Incomplete ***prior authorization*** requests are denied. Requests are considered only when completed and received before the service is provided.
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for assistance with this form.
- Respiratory care services may be prior authorized for a maximum of two months at a time.
- This form may be submitted by mail to the following address:

TMHP-CSHCN Services Program Authorization Department
12365-A Riata Trace Pkwy., Ste. 100
Austin, TX 78727

- This form may be submitted by fax to 1-512-514-4222.
- Submit only the prior authorization form. Do not submit instruction pages.
- Refer to: Chapter "Respiratory Equipment and Supplies."

Prior Authorization Request Submitter Certification Statement

Description
Read the certification statement and select "We Agree."

Client Information

Field Description	Guidelines
First name*	Enter the client's first name as indicated on the CSHCN Services Program eligibility form
Last name*	Enter the client's last name as indicated on the CSHCN Services Program eligibility form
CSHCN Services Program number*	Enter the client's ID number as indicated on the CSHCN Services Program eligibility form
Date of birth*	Enter the client's date of birth as indicated on the CSHCN Services Program eligibility form
Address/City/State/ZIP	Enter the client's address, city, state, and ZIP
Diagnoses	Enter the diagnosis code(s) relevant to the need for respiratory care services

Part 1 – Statement of Medical Necessity (Physician Completes)

Field Description	Guidelines
Procedure codes*	Check the appropriate box for procedure code 99503 or 99504 for respiratory therapy
Dates of service*	Enter the dates of service (maximum of 2 months)
Initial request date	Enter the initial request date
Extension request date	Enter the extension request date
Revision request date	Enter the revision request date
Requesting physician's name*	Enter the physician's name
NPI*	Enter the requesting physician's National Provider Identifier (NPI)

Field Description	Guidelines
Physician's signature	Physician must sign in this field
Date	Enter the date the form is signed

Part 2 – Certified Respiratory Care Practitioners (CRCP) Information and Required Signature

Field Description	Guidelines
Contact person	Enter the contact person's name
Telephone number	Enter the contact person's telephone number
Rendering CRCP provider name*	Enter the rendering provider's name
Tax ID*	Enter the rendering provider's TIN
NPI*	Enter the rendering provider's NPI
Taxonomy code*	Enter the rendering provider's taxonomy code
Benefit code*	Enter the CSN benefit code
Telephone number	Enter the provider's telephone number
Fax number	Enter the provider's fax number
Address/City/State/ZIP + 4*	Enter the provider's address, city, state, and ZIP + 4
Signature of CRCP	CRCP must sign in this field
Date	Enter the date the form is signed

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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 **512-514-4222**.

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 *CSHCN Services Program Provider Manual*.

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 CSHCN Services Program enrollment and/or personal exclusion from the CSHCN Services Program.

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 CSHCN Services Program Provider 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.*

Client Information	
First name*:	Last name*:
CSHCN Services Program number*: 9-_____-00	Date of birth*:
Address/City/State/ZIP:	
Diagnoses:	

Part 1 - Statement of Medical Necessity (Requesting Physician Completes)	
Procedure code for respiratory therapy:	
☐ 99503 (Home visit for respiratory therapy care e.g., bronchodilator, oxygen therapy, respiratory assessment, and apnea evaluation)	
☐ 99504 (Home visit for mechanical ventilation care)	
Dates of service*:_____through_____(Maximum of 2 months) Initial request date: _____ Extension request date:_____Revision request date: _____	
I certify that the patient's medical condition is such that the services requested above are medically necessary.	
Requesting physician's name (type or print)*:	NPI*:
Physician signature:	Date:

Part 2 - Certified Respiratory Care Practitioners (CRCP) Information and Required Signature		
Contact person:	Telephone:	
Rendering CRCP provider name*:		
Tax ID*:	NPI*:	
Taxonomy code*:	Benefit code*: **CSN**	
Telephone:	Fax:	
Street address*:		
City:	State:	ZIP + 4*:
Signature of CRCP:		Date: