

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form and Instructions

General Information

- Ensure the most recent version of the CSHCN Services Program Prior Authorization Request for Prescribed Pediatric Extended Care (PPECC) Services is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form**, according to the instructions. Signatures are required as indicated.
- 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.
- Submit only the referral and treatment plan form. **Do not submit instruction pages.**
- Submit the PPECC nursing assessment and plan of care along with this completed form. The PPECC services must be ordered as part of the plan of care. The PPECC can submit their plan of care document as well.
- **Refer to:** The Prescribed Pediatric Extended Care Services section of the current *Children with Special Health Care Needs (CSHCN) Services Program Provider Manual*.

Submission Information

- This form can be submitted to TMHP using the TMHP [PA on the Portal](#) (click "PA on the Portal" and enter your TMHP portal account username and password).
- With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision.
- This form can also be submitted by fax to 1-512-514-4222, or submitted by mail to the following address:

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

Prior Authorization Request Submitter Certification Statement

Description

Read the certification statement and select "We Agree."

Section A: Completed By Requesting/Prescribing Physician

Field Description	Guidelines
Client Information	
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.
Gender	Check the appropriate box to identify the client's gender.
Date of birth*	Enter the client's date of birth 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.
Address/City/State/ZIP	Enter the client's address, city, state, and ZIP + 4.

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form and Instructions

Field Description	Guidelines
Diagnoses and known allergies	Enter the diagnosis code relevant to the client's condition and any known allergies.
Date client last seen by requesting/prescribing physician	The requesting/prescribing physician must be familiar with the client and the client's medical condition(s) and must have examined the client within 30 days prior to initiation of PPECC services. (This date must be within 30 days of the start of care date.)
Requesting/Prescribing Physician Information	
Name*	Enter the requesting /prescribing physician's name.
NPI*	Enter the requesting /prescribing physician's National Provider Identifier (NPI).
License number	Enter the requesting /prescribing physician's license number.
Telephone number	Enter the requesting /prescribing physician's telephone number.
Address/City/State/ZIP	Enter the requesting /prescribing physician's address, city, state, and ZIP + 4.
Physician Ordered Services*	Check each box that applies for the services that have been ordered by the physician to be rendered in the PPECC. Add additional comments as necessary.
Prior authorization for PT, OT, ST, hospice, and/or respiratory therapy services (if applicable)	If known, include the authorization number of the PT, OT, ST, hospice, and/or respiratory therapy services that have been authorized separately.
Client's current diagnoses and medical condition(s)	Describe the client's current diagnoses and medical condition(s). Include documentation of medical necessity that indicates the client's need for on-going skilled nursing services beyond the level of Home Health skilled nursing and Home Health aide services for chronic conditions not expected to resolve in 60 calendar days or less. (Attach additional documents as necessary.)
Requesting or Prescribing Physician Signature	The form must be signed and dated by the requesting or prescribing physician. A valid electronic signature is accepted.
Plan of Care (POC)	A signed and dated copy of the POC must be submitted with the Prior Authorization request. The POC must be signed before the Start of Care (SOC) date by the practitioner who ordered PPECC services
Requesting or Prescribing Physician's signature and date	Verbal orders are not accepted. The form must be signed and dated by the requesting or prescribing physician and the PPECC provider. All signatures must be current, unaltered, original, and handwritten.
Services Client Currently Receives at Home	Check all services the client is currently receiving at home and include the amount, duration, and frequency of the services. Check "unknown" if the information is not available.

Section B: Completed by PPECC Facility

Field Description	Guidelines
Client First Name*	Enter the client's first name.
Client Last Name*	Enter the client's last name.
Gender	Check the client's gender.
Date of Birth*	Enter the client's date of birth.
CSHCN Services Program number*	Enter the client's ID number as indicated on the CSHCN Services Program eligibility form.
Address/City/State/ZIP	Enter the client's address, city, state, and ZIP.

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form and Instructions

Field Description	Guidelines
Diagnoses	Enter the diagnosis code relevant to the client's condition and any known allergies.
Rendering PPECC Facility name*	Enter the name of the PPECC Facility
Rendering PPECC Facility NPI*	Enter the National Provider Identifier (NPI) of the PPECC facility.
Rendering PPECC Facility Tax ID*	Enter the provider's Tax Identification Number (TIN).
Taxonomy code*	Enter the provider's taxonomy code.
Benefit code*	Benefit code "CSN" is prepopulated in this field.
Contact name	Enter the contact person's name.
Telephone number	Enter the provider's telephone number.
Fax number	Enter the provider's fax number.
Address/City/State/ZIP*	Enter the PPECC facility's address, city, state, and ZIP + 4.
Request status	Check the appropriate type of service being requested: new request, extension of an existing request, update to an existing request.
Requested procedures*	Check the type of services requested and include the procedure code that will be billed on the claim. Include a description of the nursing services required and include any necessary additional information.
Start of Care Date (mm/dd/yy) *	Indicate the start of care date
End of Care Date (mm/dd/yy) *	Indicate the end of care date
Scheduled days	Check the days the client will receive services at the PPECC facility.
Hours of Attendance	Provide the information requested concerning the client's attendance in the PPECC facility. The total number of hours cannot exceed 400 hours.
Original Start of Care Date (mm/dd/yy) (if request is extension or revision)	If this request is for an extension or revision, indicate the original start of care date.
Original End of Care Date (mm/dd/yy) (if request is extension or revision)	If this request is for an extension or revision, indicate the original end of care date.
Reason hours were not used for original request (if revision/extension):	Indicate the reason the hours were not used for original request (if revision/extension).
Date the PPECC nursing assessment was completed	Enter the date the PPECC nursing assessment was completed.
Name of RN who completed the nursing assessment	Enter the name of the RN who completed the nursing assessment.
Title	Enter the title of the RN who completed the nursing assessment.
Credentials	Enter the credentials of the RN who completed the nursing assessment.
Signature/Date	The signature of the RN who completed the nursing assessment.

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form and Instructions

Field Description	Guidelines
PPECC Plan of Care (POC)	<p>The PPECC POC must be initiated, signed, and dated by a qualified individual (e.g., registered nurse, advanced practice registered nurse, physician assistant, or physician who is employed by the PPECC in coordination with the interdisciplinary team). The POC must also be signed and dated by the client or the client’s responsible adult before the start of care.</p> <p>The POC must be submitted with this prior authorization request and must include the following:</p> <ul style="list-style-type: none"> • Client information: name, date of birth, gender, and CSHCN Services Program client number • The requesting/prescribing physician’s license number • The PPECC provider’s Tax Identification Number (TIN) • Date the PPECC nursing assessment was completed • The name, title, credentials, and signature of the team member preparing the POC • Date the client was last seen by the requesting/prescribing physician • The Start Of Care (SOC) date for PPECC services, including scheduled days, and hours of attendance • All diagnoses and known allergies • Prognosis • Nursing services requested including amount , duration, and frequency • The client’s mental status • The types of therapies requested including amount, duration, and frequency • Equipment and supplies needed • Rehabilitation potential • Prior and current functional limitations • Activities permitted • Nutritional requirements including type, method of administration, and frequency • Mediations including dose, route, and frequency • Treatments including amount and frequency • Wound care orders and measurements • Safety measures to protect against injury • Method of transportation to the PPECC • Discharge Plan • Responsible adult training needs
Name of PPECC team member who prepared the POC	Enter the name of PPECC team member who prepared the POC. This is the team member who prepared the client’s POC for PPECC services.
Title	Enter the title of the PPECC team member who prepared the POC.
Credentials	Enter the credentials of the PPECC team member who prepared the POC.
Signature/Date	The signature of the PPECC team member who prepared the POC. The PPECC team member who prepared the PPECC POC must be the person who signs this section of the prior authorization form.
Certification and PPECC Representative Signature	Check the boxes to confirm the attestation statements.
PPECC representative’s signature and date	Verbal orders are not accepted. The form must be signed and dated by the requesting/prescribing physician and the PPECC provider. All signatures must meet the requirements listed in Chapter 4, “Authorizations,” in the current <i>CSHCN Services Program Provider Manual</i> .

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form

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

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form

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: Completed by Requesting/Prescribing Physician

Client Information

First Name*:	Last Name*:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth*:
CSHCN Services Program Client Number*: 9-_____ -00	
Address (Street, City, State, ZIP):	
Diagnoses and known allergies:	
Date client last seen by requesting / prescribing physician:	

Requesting or Prescribing Physician Information

Name*:		
NPI*:		
License number:	Telephone:	
Street address:		
City:	State:	ZIP + 4:

Physician Ordered PPECC Services for this Prior Authorization Request

Type of PPECC Service*	Additional Comments
<input type="checkbox"/> Nursing services	
<input type="checkbox"/> Medication administration	
<input type="checkbox"/> Diet and nutritional needs	
<input type="checkbox"/> Permitted activity level	
<input type="checkbox"/> Other (e.g., psychosocial, functional/ developmental)	
<input type="checkbox"/> Transportation provided by:	<input type="checkbox"/> Responsible adult <input type="checkbox"/> PPECC <input type="checkbox"/> Other (specify):

Note: Physical therapy (PT), occupational therapy (OT), speech therapy (ST), hospice and respiratory therapy services will not be prior authorized using this form. Therapy and hospice services must be prior authorized separately using the appropriate CSHCN Services Program prior authorization form.

Prior authorization number for PT, OT, ST, hospice, and/or respiratory therapy services (if applicable):

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form

Section A: Completed by Requesting/Prescribing Physician

Statement of Medical Necessity and Provider Signature

Describe the client's current diagnoses and medical condition(s). Include documentation of medical necessity that indicates the client's need for on-going skilled nursing services beyond the level of Home Health skilled nursing and Home Health aide services for chronic conditions not expected to resolve in 60 calendar days or less. (Attach additional documents as necessary.)

Current diagnoses and medical condition(s):

Documentation of medical necessity:

Requesting Physician Signature

I certify that the patient's medical condition is such that the treatment requested above is medically necessary.

Signature:

Date:

Services Client Currently Receives at Home

Type	Amount	Duration	Frequency	Unknown
<input type="checkbox"/> Nursing services				<input type="checkbox"/> Unknown
<input type="checkbox"/> Physical Therapy				<input type="checkbox"/> Unknown
<input type="checkbox"/> Occupational Therapy				<input type="checkbox"/> Unknown
<input type="checkbox"/> Speech Therapy				<input type="checkbox"/> Unknown
<input type="checkbox"/> Dietary/nutritional				<input type="checkbox"/> Unknown
<input type="checkbox"/> Respiratory				<input type="checkbox"/> Unknown
<input type="checkbox"/> Hospice				<input type="checkbox"/> Unknown
<input type="checkbox"/> Other:				<input type="checkbox"/> Unknown

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form

Section B: Completed by PPECC Facility		
Client Information		
First Name*:	Last Name*:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth*:	
CSHCN Services Program Client Number*: 9- _____ -00		
Address (Street, City, State, ZIP):		
Diagnoses:		
Rendering PPECC Provider Information		
Facility name*:		
Facility NPI*:	Facility Tax ID*:	
Taxonomy code*:	Benefit code*: CSN	
Contact name:		
Telephone:	Fax:	
Street address*:		
City:	State:	ZIP + 4*:
Type of Request		
Request status: <input type="checkbox"/> New <input type="checkbox"/> Revision <input type="checkbox"/> Extension – Initial SOC Date (mm/dd/yy):		
Requested Procedure(s)		
Type of services requested	Procedure code*	
<input type="checkbox"/> PPECC services		
<input type="checkbox"/> Transportation		Method of transportation to PPECC:
Describe the PPECC services required and include any necessary additional information (<i>Refer to the appropriate manual section for specific prior authorization requirements</i>):		
Days/Hours Requested		
Start of Care Date* (mm/dd/yy) this request: <input type="checkbox"/> N/A	End of Care Date* (mm/dd/yy) this request: <input type="checkbox"/> N/A	
Scheduled days: <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat		
Hours of Attendance:		

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form

Section B: Completed by PPECC Facility

# of Weeks	# of Days/Wk	# of Hrs/Day	Total Hrs this request	Original # of Hrs Used (if revision/extension)	Total # of Hrs per Yr (*Not to exceed 400 Hrs)

Original Start of Care Date (mm/dd/yy) if revision/extension: <input type="checkbox"/> N/A	Original End of Care Date (mm/dd/yy) if revision/extension: <input type="checkbox"/> N/A
--	--

Reason hours were not used for original request (if revision/extension):

Initial Nursing Assessment *(The PPECC nursing assessment must be submitted with this prior authorization request.)*

Date the PPECC nursing assessment was completed:

Name of RN who completed the nursing assessment:

Title:	Credentials:
--------	--------------

Signature:	Date:
------------	-------

PPECC Plan of Care (POC) – *The Plan of Care (POC) must be submitted with this prior authorization request and must include all of the information listed below:*

Last seen by requesting/prescribing physician:

The client’s mental status:

All diagnoses and known allergies:

Diagnoses:

Known allergies:

Functional limitations:

Prior:

Current:

Rehabilitation potential:

Permitted activity level:

Prognosis:

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form

Section B: Completed by PPECC Facility

Responsible adult training needs:

Equipment and supplies needed:

Nursing, therapy, and other services requested:

Type	Hours/Day	Days/Wk	# of Weeks	Total Hours (**Not to exceed 400 Hrs/Yr)
<input type="checkbox"/> Nursing Services				
<input type="checkbox"/> Occupational Therapy**				
<input type="checkbox"/> Physical Therapy**				
<input type="checkbox"/> Speech Therapy**				
<input type="checkbox"/> Respiratory Therapy**				
<input type="checkbox"/> Psychosocial Services				
<input type="checkbox"/> Nutritional/dietary				
<input type="checkbox"/> Transportation Services				
<input type="checkbox"/> Caregiver Training				
<input type="checkbox"/> Hospice**				
<input type="checkbox"/> Other				

**** Note:** PT/OT/ST, hospice, and respiratory therapy services will not be prior authorized using this form. Therapy and hospice services must be prior authorized separately using the appropriate form.

Treatments:

Type	Amount	Frequency

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form

Section B: Completed by PPECC Facility

Wound care orders and measurements:

Orders

Measurements

Nutritional requirements:

Diet

Method of administration

Frequency

Medications:

Medication

Dose

Route

Frequency

Medication

Dose

Route

Frequency

Safety measures to protect against injury:

Discharge plan:

PPECC Team Member Who Prepared the POC

Name of PPECC team member who prepared the POC:

Title:	Credentials:
--------	--------------

Signature:

Date:

--	--

CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form

Section B: Completed by PPECC Facility

Certification and PPECC Representative Signature

By signing this form:

- I certify that the client named above requires care as indicated on this prior authorization request form.*
- I certify that the PPECC Nursing Assessment and the Plan of Care for the identified client have been attached to this prior authorization request and include measurable goals and objectives.*

PPECC representative signature:

Date: