Outpatient Mental Health Services 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 **512-514-4212**.

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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Instructions: All providers must complete Sections A-F and sign and date at the bottom of page 5. For Psychotherapy requests, complete sections G-I. For Psychological or Neuropsychological Testing requests, complete Sections J-K.
For Psychiatric Diagnostic Evaluation requests, complete Section L.

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.*

A. Identifying Information

Client Information

Client Name*:				
Medicaid Number*:				Date:
Date of Birth*:	Age:	Sex:	Date Current Treatment Began:	
Current Living Arrangements:	☐ Independently ☐ With parent(s) ☐ Group/foster home ☐ Residential treatment center ☐ Other (list):			

Rendering Provider Information

Rendering Provider*:		
Street Address:		
City:	State:	ZIP + 4*:
Telephone:	Fax:	
Provider Credentials:	Professional License Number:	
Tax ID*:	NPI*:	
Taxonomy*:	Benefit Code*:	

B. Current DSM Diagnosis (list all appropriate diagnosis codes)

C. Court ordered service?

☐ Yes ☐ No	Court order signed by judge must be attached.

D. DFPS directed service?

☐ Yes ☐ No	DFPS directive or summary signed by employee must be attached.
DFPS employee's name:	DFPS employee's phone number:

E. History

Prior psychiatric inpatient treatment?	☐ Yes ☐ No	Age at first admission:
Prior substance abuse?	☐ None ☐ Alcohol ☐ Drugs (specify):	
Current substance abuse?	☐ None ☐ Alcohol ☐ Drugs (specify):	

* Essential/Critical field

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E. History

Significant medical conditions:

F. Current Psychiatric Medications (include dose and frequency)

G. Recent Primary Symptoms Requiring Additional Psychotherapy

Provide details, including dates of recent occurrence, frequency, duration, and severity as applicable.

H. Psychotherapy Treatment Plan

Measurable short term goals (*attach additional pages if necessary*):

Specific therapeutic interventions to be utilized:

Most recent measurable progress:

Measureable expected outcome(s) of psychotherapy:

* Essential/Critical field

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Measurable discharge criteria:	Expected Discharge Date:
Aftercare plan:	

I. Number of Psychotherapy Sessions Requested (limit 10 per request)

List the specific procedure codes requested*:	
How many of each type*?	☐ Individual: _____ Indicate duration: ☐ 30 min. ☐ 45 min. ☐ 60 min. ☐ Group: _____ ☐ Family: _____
Start of request*:	End of request*:

J. Psychological / Neuropsychological Testing Requested

☐ Psychological testing procedure code*:	No. of hours requested:
☐ Neuropsychological testing procedure code*:	No. of hours requested:
Start of request*:	End of request*:

K. Rationale Supporting Medical Necessity for Testing (attach additional pages if necessary)

Previous history and testing results:
Current symptoms/concerns warranting futher testing:
Specific proposed tests to be administered:

* Essential/Critical field

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L. Psychiatric Diagnostic Evaluation Requested	
Has the patient had a psychiatric evaluation with this provider in the current calendar year? If yes, complete this section. If not, prior authorization is *not* required.	
Procedure Code Requested*:	
Rationale supporting medical necessity for additional evaluation, including recent client history and primary symptoms:	
Start of Request*:	End of Request*:

M. Provider Signature	
Requesting Provider Printed Name*:	
Tax ID:	NPI*:
Provider Signature (stamped signatures not accepted):	Date:

* Essential/Critical field