CSHCN Services Program Authorization and Prior Authorization Request for Hemophilia Blood Factor Products Form and Instructions

General Information

- Medical review is necessary for any diagnosis other than those listed in the *CSHCN Services Program Provider Manual* and for exceptions to any diagnosis restrictions. Complete this form when medical review is required for approval of blood factor products.
- Ensure the most recent version of the Authorization Request and Prior Authorization for Hemophilia Blood Factor Products form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Incomplete ***authorization*** requests will cause the claim to be denied.
- 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.
- This form may be submitted by mail to the following address:

  TMHP-CSHCN Services Program Authorization Department
  12357-B Riata Trace Parkway Ste #100 MC-A11
  Austin, TX 78727
- This form may be submitted by fax to 1-512-514-4222.
- Submit only the authorization form. Do not submit instruction pages.
- Refer to: Chapter 31, "Physician" or Chapter 24, "Hospital."
- Physician prescription must accompany this form.

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 relevant to the need for hemophilia blood factor products.

Procedure Information

Field Description	Guidelines
Product name	Enter the product name
Product manufacturer	Enter the product manufacturer name
National drug code (NDC)	Enter the NDC
HCPCS code	Enter the Healthcare Common Procedure Coding System (HCPCS) code
Product quantity (per I.U.)	Enter the product quantity

Prescribing Physician Information

Field Description	Guidelines
Physician name	Enter the physician's name
Telephone number	Enter the physician's telephone number
Physician signature	Physician must sign in this field
Date	Enter the date the form is signed

Provider Information and Required Signature

Field Description	Guidelines
Provider name	Enter the provider's name
Provider contact name (if any)	Enter the provider's contact name
CSHCN TPI	Enter the provider's CSHCN Texas provider identifier (TPI)
NPI	Enter the provider's national provider identifier (NPI)
Taxonomy code	Enter the 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	Enter the provider's address, city, state, and ZIP
Provider signature	Provider must sign in this field
Date	Enter the date the form was signed

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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 Authorization and Prior Authorization Request for Hemophilia Blood Factor Products

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

Product Information:	
Product name:	
Product manufacturer:	
National drug code (NDC):	
HCPCS code:	
Product quantity (per I.U.):	

Prescribing Physician Information:	
I certify that the patient's medical condition is such that the treatment requested above is medically necessary.	
Physician name:	Telephone number:
Physician signature:	Date:

Provider Information and Required Signature:	
Provider name:	Provider contact name (if any):
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Telephone number:	Fax number:
Address/City/State/ZIP:	
Provider signature:	Date: