Home Telemonitoring Services Prior Authorization Request
Texas Medicaid

Prior authorization (PA) requests can be submitted using TMHP's PA on the Portal, by fax or mail.
To access PA on the Portal, go to www.tmhp.com. Documents will be immediately received by the PA Department, resulting in a quicker decision.
To submit by fax, please send the form to the Texas Medicaid Special Medical Prior Authorization department at 1-512-514-4213.

This form may also be submitted by mail to:
Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Austin, TX 78727

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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All sections of the form must be completed unless otherwise stated.

Section A: Client information (completed by home health agency or outpatient hospital)			
Name	First:	Last:	MI:
Medicaid number:		Date of birth:	

Section B: Requested telemonitoring service information (completed by home health agency or outpatient hospital)

Home telemonitoring qualifying conditions: ☐ Diabetes ☐ Hypertension

Risk Factors for clients with diabetes or hypertension (check all that apply):

☐ Two or more hospitalizations in the prior 12-month period

☐ Frequent or recurrent emergency department admissions

☐ Documented history of poor adherence to medication regimens

☐ Documented history of falls in the prior six-month period

☐ Limited or absent informal support systems

☐ Living alone or being home alone for extended periods of time

☐ Documented history of care access challenges

Additional home telemonitoring qualifying conditions for clients 20 years of age or younger:

☐ Mechanical ventilation ☐ End-stage solid organ disease ☐ Transplant

Section C: Authorization period (completed by home health agency or outpatient hospital)	
Requested start date:	Requested end date:
Procedure code(s):	
Physician-ordered frequency of clinical data transmission:	
Comments (optional):	

Section D: Ordering physician information (must be completed by home health agency, outpatient hospital, or physician ordering home telemonitoring)

Physician's name:

TPI or NPI:

Physician's dated signature is required unless one of the following from the physician is attached to the request:

- Signed and dated prescription
- Dated written order
- Dated documented verbal order (may be on a plan of care or treatment plan)

Physician's signature: Date signed:

Section E: Telemonitoring provider information (completed by home health agency or outpatient hospital)	
Provider printed name:	Contact person:
Address/City/ZIP:	
Telephone number:	Fax number:
TPI:	NPI:
Provider's signature:	Date signed: