Home Telemonitoring Services Prior Authorization Request
Children with Special Health Care Needs (CSHCN) Services Program

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

Section A: Client information

This section to completed by home health agency or outpatient hospital

First name*:	Last name*:	
CSHCN Services Program number*: 9-_____-00		Date of birth*:

SectionB:Requested telemonitoring service information

This section to be 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 visits

☐ Documented history of poor adherence to ordered 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:

☐ Congestive Heart Failure ☐ End Stage Solid Organ Disease

☐ Organ Transplant Recipients ☐ Requiring Mechanical Ventilation

Section C: Authorization period

This section to be completed by home health agency or outpatient hospital

Requested start date*:	Requested end date*:
Procedure code(s) (Select all that apply)*	
☐ S9110 modifier U1 (Initial Set Up)	☐ S9110 (Data Transmission)
Physician ordered frequency of clinical (S9110) data transmission*:	
Comments (optional):	

* Essential/Critical field

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Section D: Requesting physician information		
To be completed by requesting physician or designee		
Requesting physician/designee name*:		
Street address:		
City:	State:	ZIP + 4:
Telephone:	Fax:	
NPI*:	Taxonomy:	Benefit Code:
Physician/Designee signature:		Date signed:

Section E: Rendering telemonitoring provider information			
This section to be completed by home health agency or outpatient hospital			
Rendering provider printed name*:			
Contact person:			
Street address*:			
City:	State:	ZIP + 4*:	
Telephone:	Fax:		
Tax ID*:	NPI*:	Taxonomy:	Benefit Code*:
Provider's signature:		Date signed:	

* Essential/Critical field