Medicaid Certificate of Medical Necessity for Reduction Mammaplasty

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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Section A: **To be completed by the physician or physician staff**		
Client Information		
Name:	Medicaid number:	
Height:	Weight:	Date of birth:
Breast size (must include photograph):		
Physician Information		
Name:	Telephone:	Fax number:
Address:		
Medical license number:	TPI:	NPI:
Taxonomy:	Benefit Code:	

Section B: **To be completed by the physician**		
Client has evidence of a restrictive pulmonary defect (provide results of pulmonary function studies in narrative section).		Yes ☐ No ☐
Client has evidence of severe neck and back pain (provide results of therapies tried in narrative section).		Yes ☐ No ☐
Client has evidence of ulnar paresthesia from thoracic nerve root compression (provide results of therapies tried in narrative section).		Yes ☐ No ☐
Client has evidence of ischemic heart disease (provide results of abnormal EKG and/or coronary angiography).		Yes ☐ No ☐
This client, if age 40 or over, has had a mammogram within the past year that was negative for cancer.		Yes ☐ No ☐
Estimated the grams of breast tissue to be removed from each breast.	Right:	Left:
The client is in a weight reduction program and has lost ___________lbs.		Yes ☐ No ☐

Section C: **Physician prescribing Reduction Mammaplasty must complete narrative information regarding the medical necessity as requested above.**	
Narrative note for medical necessity (write legibly):	
Physician signature:	Date:

Refer to the Reduction Mammaplasty policy in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (Vol. 2, Provider Handbooks) of the current *Texas Medicaid Provider Procedures Manual*.