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

Obstetric Ultrasound Prior Authorization Request
Texas Medicaid Program

This form is to be used to obtain prior authorization for greater than three obstetric ultrasounds per pregnancy. Forms that are submitted without all of the required information will be returned for correction. Fax the completed form to 1-512-302-5039 or request prior authorization online though the TMHP provider prior authorization portal at www.tmhp.com.

Client Information

First Name:	Last Name:	Middle Initial:
DOB:	Client Medicaid Number:	

Requesting Provider Information

Name:	Address:	
City:	State:	Zip:
TPI:	NPI:	Taxonomy:
Telephone number:	Fax number:	

Performing/Facility Provider Information (if different from requesting provider)

Name:	Address:	
City:	State:	Zip:
TPI:	NPI:	Taxonomy:
Telephone number:	Fax number:	

Procedure(s) Requested: CPT Codes

CPT Code	Qty	Trimester Performed	From Date	To Date		CPT Code	Qty	Trimester Performed	From Date	To Date

Client's Estimated Date of Confinement (EDC):	Gravidity:	Parity:	Diagnosis:

Clinical documentation supporting medical necessity for obstetric ultrasounds includes treatment history, treatment plan, medications, and previous imaging results:

If requesting serial ultrasounds, please provide intended frequency and clinical rationale.

Provider (Physician, CNM, NP, CNS, or PA) must complete and sign this form prior to requesting authorization.

Requesting Provider Signature:	Date:
Print Name:	License Number: