

## CSHCN Services Program Instructions for Prior Authorization Request for Hospice Services

### General Information

- Ensure the most recent version of the Prior Authorization Request for Hospice Services form is submitted. The form is available on the TMHP website at [www.tmhp.com](http://www.tmhp.com).
- **Complete all sections of this form.**
- Incomplete **prior authorization** requests are denied. Requests are considered only when completed and received before the service is provided.
- 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 prior authorization form. Do not submit instruction pages.
- **Refer to:** Chapter 23, "Hospice," in the current *CSHCN Services Program Provider Manual*.

### 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
Hospice diagnoses	Enter the diagnosis code(s) relevant to the need for the hospice services

### Requested Services

Field Description	Guidelines
Start of care date (mm/dd/yy)	Enter the start of care date
End of care date (mm/dd/yy)	Enter the end of care date
Type of hospice care	Enter the type of hospice care (routine home, continuous home, inpatient hospice, respite)
Describe direct care to be provided	Describe the direct care to be provided such as durable medical equipment (DME), supplies, and medications anticipated for the care of the client

### Provider Information and Required Signatures

Field Description	Guidelines
<b>Hospice Provider</b>	
Hospice provider name	Enter the name of the hospice provider
CSHCN TPI	Enter the hospice provider's TPI
NPI	Enter the hospice provider's NPI

Field Description	Guidelines
Taxonomy code	Enter the hospice provider's taxonomy code
Benefit code	Enter CSN
Telephone number	Enter the hospice provider's telephone number
Fax number	Enter the hospice provider's fax number
Address/City/State/ZIP	Enter the hospice provider's address, city, state, and ZIP
Authorized signature	Authorize person must sign in this field
Date	Enter the date the form is signed
<b>Referring Physician</b>	
Referring physician name	Enter the name of the referring physician
Telephone number	Enter the referring physician's telephone number
Fax number	Enter the referring physician's fax number
Referring physician's signature	Referring physician must sign in this field
Date	Enter the date the form is signed

### Additional Requirements

- Hospice providers must submit the "CSHCN Services Program Prior Authorization Request for Hospice Services form" or the provider's plan of care (POC) if it includes:
  - The same information as the "CSHCN Services Program Prior Authorization Request for Hospice Services" form.
  - The hospice provider's and referring physician's signatures.
- Prior authorization requests for hospice may be granted for up to a maximum of six months.
- If the client requires hospice care beyond the initial six-month period, authorization for additional six-month periods may be considered with a new request that includes the following documentation:
  - An updated "CSHCN Services Program Prior Authorization Request for Hospice Services" form or a POC that includes the same information as the CSHCN Services Program Prior Authorization Request for Hospice Services form and the hospice provider's and physician's signatures.
  - An updated description of all direct care, durable medical equipment, supplies, and medications anticipated for the care of the client.

# CSHCN Services Program Prior Authorization Request for Hospice Services



## 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 Prior Authorization Request for Hospice Services



Client Information:			
First name:		Last name:	
CSHCN Services Program number: 9- _____ -00		Date of birth:	
Address/City/State/ZIP:			
Hospice diagnoses:			
Requested Services:			
Start of care date (mm/dd/yy):		End of care date (mm/dd/yy):	
Type of hospice care:	<input type="checkbox"/> Routine home	<input type="checkbox"/> Continuous home	<input type="checkbox"/> Inpatient hospice <input type="checkbox"/> Respite
Describe direct care to be provided. Include durable medical equipment, supplies, and medications anticipated for the care of the client:			
Provider Information and Required Signatures:			
Hospice Provider			
Hospice provider name:			
Hospice contact name:			
CSHCN TPI:		NPI:	
Taxonomy code:		Benefit code: <b>CSN</b>	
Telephone number:		Fax number:	
Address/City/State/ZIP:			
Authorized signature:			Date:
Referring Physician			
Referring physician name:			
Referring physician contact name:			
Telephone number:		Fax number:	
I certify that the client is terminally ill with a medical prognosis of six months or less to live, if the illness runs the normal course.			
Referring physician's signature:			Date: