CSHCN Services Program Instructions for Prior Authorization Request for Inpatient Psychiatric Care Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Inpatient Psychiatric Care form is submitted. The form is available on the TMHP website at 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 24, "Hospital," in the current *CSHCN Services Program Provider Manual*.
- All inpatient psychiatric care stays must be prior authorized. The attending physician and the hospital must be actively enrolled as providers in the CSHCN Services Program.

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
Last name	Enter the client's last name as indicated on the CSHCN Services Program
CSHCN Services Program	Enter the client's ID number as indicated on the CSHCN Services Program
Date of birth	Enter the client's date of birth as indicated on the CSHCN Services
Address/City/State/ZIP	Enter the client's address, city, state, and ZIP
Telephone number	Enter the client's telephone number
Parent or guardian	Enter the client's parent or guardian name
Presumptive diagnoses	Enter the presumptive diagnosis code(s) at the time of admission

Admission Information

Field Description	Guidelines
Briefly describe why the client's needs cannot be met in an outpatient setting	Briefly describe why the client's needs cannot be met in an outpatient setting
Date of inpatient stay (*not to exceed five days*)	Enter the from and through date of the inpatient stay
Briefly describe transfer plans	Indicate the transfer plans

Attending Physician

Field Description	Guidelines
Attending physician's name	Enter the attending physician's name
CSHCN TPI	Enter the attending physician's CSHCN TPI
NPI	Enter the attending physician's NPI
Taxonomy code	Enter the attending physician's taxonomy code
Benefit code: CSN	The CSN benefit code has already been entered in the form

Facility Information

Field Description	Guidelines
Facility name	Enter the facility's name
Facility telephone number	Enter the facility's telephone number
Facility Address/City/State/ZIP	Enter the facility's address, city, state, and ZIP
Facility CSHCN TPI	Enter the facility's Texas provider identifier (TPI)
Facility NPI	Enter the facility's national provider identifier (NPI)
Facility taxonomy code	Enter the facility's taxonomy code
Facility benefit code	Enter CSN
Contact person	Enter the facility's contact person's name

Additional Requirements

- Prior authorization requests for inpatient psychiatric care must be submitted before or on the day of the client's admission, unless the admission is after 5 p.m., or on a holiday, or a weekend. In these cases, the TMHP-CSHCN Services Program must receive it by 5 p.m. on the next business day following admission.
- Coverage is limited to inpatient assessment and crisis stabilization and should be followed by referral to an appropriate behavioral health program.
- Coverage is limited to a maximum of 5 days per calendar year.

CSHCN Services Program Prior Authorization Request for Inpatient Psychiatric Care

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 Inpatient Psychiatric Care

Client Information	
First name:	Last name:
CSHCN Services Program number: 9- _____-00	Date of birth:
Address/City/State/ZIP:	
Telephone number:	
Parent or guardian:	Presumptive diagnoses:

Admission Information		
Briefly describe why the client's needs cannot be met in an outpatient setting:		
Date of inpatient stay: _____ through _____ (Not to exceed five days)		
Briefly describe transfer plans:		

Attending Physician Information		
Attending physician's name:		
CSHCN TPI:	NPI:	
Taxonomy code:		Benefit Code: **CSN**

Facility Information	
Facility name:	
Facility contact name:	
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Telephone number:	Fax number:
Address/City/State/Zip:	