

# CCP Prior Authorization Private Duty Nursing 6-Month Authorization

## 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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Client name:	Client Medicaid number:	Date:
<p>The following criteria must be met before seeking a 6-month authorization of private duty nursing (PDN) services. Remember that authorization is a condition for reimbursement; it is not a guarantee. Each nurse provider should verify the continued Medicaid coverage for each client for each month of service.</p>		
<input type="checkbox"/>	Client has received PDN services for at least 3 months.	
<input type="checkbox"/>	Client has had no new significant diagnosis, treatment, illness/injury or hospitalization in at least 6 months that would be expected to affect the need for PDN services.	
<input type="checkbox"/>	Client's physician and client/parent/guardian do not anticipate any significant changes in the client's condition for the requested authorization period.	
<input type="checkbox"/>	The nurse provider will ensure that a new physician plan of care is obtained within 30 calendar days of the authorization expiration date and will be maintained with the client's record.	
<input type="checkbox"/>	The nurse provider will advise TMHP-CCP of any significant changes in the client's condition, treatments or physician orders which occur during the authorization period if the number of PDN hours needs to change.	
<input type="checkbox"/>	The client's physician, client/parent/guardian, and nurse provider understand that the authorization may be changed during the authorization period if the client's condition or skilled needs change significantly.	
<p><b>All required acknowledgments must be signed and dated.</b> I have read and understand the above information.</p>		
Signature of the client/parent/guardian		Date
Brief statement of why a maximum 6-month recertification is appropriate for this client:		
I have discussed the above information with the client/parent/guardian.		
Signature of nurse provider		Date
<p><b>To be completed by the client's physician</b></p>		
The above services are medically necessary, the client's condition is stable and this request supports the client's health and safety needs.		
Signature of the client's physician		Date
Printed name:		
Telephone:	Fax number:	
Mailing address (Street/City/State/ZIP):		
<b>Fax completed request to TMHP-CCP at 1-512-514-4212</b>		