CCP Prior Authorization Request Form

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. To submit by fax, send to **512-514-4212**.

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

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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Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

Request for:	☐ **DME**	☐ **Supplies**	☐ **Private Duty Nursing**	☐ **PPECC**	☐ **Inpatient Rehabilitation**	☐ **Other**

A: Client Information

Client Name (Last, First, M.I.)*:	
Medicaid Number*:	Date of Birth*:

B: Rendering Provider/Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information

Name*:	Telephone:	Fax:	
Street Address*:			
City:	State:	ZIP + 4*:	
Tax ID*:	NPI*:	Taxonomy*:	Benefit Code*:
QRP Name:	QRP Tax ID:	QRP NPI:	
QRP Taxonomy:	QRP Benefit Code:		
QRP Street Address:			
City:	State:	ZIP + 4:	

C: Type of Request

☐ Initial / New Client	Requested Start Date*:	Requested End Date*:
☐ Recertification	Requested Start Date*:	Requested End Date*:
☐ Revision**	Revised Start Date*:	End Date*: (Cannot extend beyond current authorization period.)
** Reason for Revision:		

D: Diagnosis and Medical Necessity of Requested Services (Initial and Recertification)

E: Dates of Service and HCPCS Code

Dates of Service:	From*:	To*:	
HCPCS Code* / Modifier	Brief Description of Requested Services	Quantity* / Frequency*	Retail Price

* Essential/Critical field

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E: Dates of Service and HCPCS Code

Note: *HCPCS codes and descriptions must be provided.*

F: Primary Practitioner's Certifications (To be completed by the requesting practitioner)

By requesting the identified DME and/or medical supplies, I certify:

- The client is under 21 years of age AND
- The prescribed items are appropriate and can safely be used by the client when used as prescribed

By requesting Private Duty Nursing, I certify:

- The client is under 21 years of age AND
- The client's medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

By requesting PPECC services, I certify:

- The client is under 21 years of age AND
- The client's medical condition is sufficiently stable to permit safe delivery of PPECC services as described in the PPECC plan of care.

Note: *Signatures from chiropractors and doctors of philosophy (PhDs) will not be accepted. Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP) and Physician Assistant (PA) providers may sign on behalf of the physician for Private Duty Nursing, Physical, Occupational, and Speech Therapy Services when the physician delegates this authority. Signature stamps and date stamps are not acceptable.*

Signature of requesting physician:	Date:

Printed or typed name of physician*:

NPI*:	License No.:

* Essential/Critical field