CSHCN Services Program Authorization Request for Initial Outpatient Therapy (TP1) Form and Instructions

General Information

- Ensure the most recent version of the Authorization Request for Initial Outpatient Therapy (TP1) form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Incomplete ***authorization*** requests will cause the claim to be denied.
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 or 1-512-514-3000, option 2, 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 authorization form. Do not submit instruction pages.
- Refer to: Chapter 30, "Physical Medicine and Rehabilitation" and Chapter 36, "Speech-Language Pathology (SLP) Services."

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/ZIP	Enter the client's address, city, and ZIP
Diagnosis	Enter the diagnosis code relevant to the client's condition.

Evaluation Summary

Field Description	Guidelines
Date of evaluation	Enter the date of evaluation. ***Note:*** *A copy of the initial evaluation must be attached.*
Type of evaluation	Check the appropriate type of evaluation
Comments	

Service Request

Field Description	Guidelines
Service request	Indicate procedure code(s), modifier, the dates of service, and the frequency per week or month. Dates of service cannot exceed six months. If possible, end requested date(s) of service on the last day of a month.
Physician name, signature, and date	Indicate the prescribing physician's name, signature, and date of signature
PT name, signature, and date	Indicate the physical therapist's name, signature, and date of signature
OT name, signature, and date	Indicate the occupational therapist's name, signature, and date of signature

Field Description	Guidelines
SLP name, signature, and date	Indicate the speech language pathologist's name, signature, and date of signature

Provider Information and Required Signature

Field Description	Guidelines
Provider name	Enter the provider's name
CSHCN TPI	Enter the provider's Texas provider identifier (TPI)
NPI	Enter the provider's national provider identifier (NPI)
Taxonomy code	Enter the provider's taxonomy code
Benefit code	Enter CSN
Provider contact name	Enter the provider's contact name
Telephone number	Enter the provider's telephone number
Fax number	Enter the provider's fax number
Address/City/ZIP	Enter the provider's address, city, and ZIP
Provider signature	Provider must sign in this field
Date	Enter the date the form is signed

Additional Requirements

- The GP or the GO modifier is required when requesting authorization for PT and OT services. PT should be requested using the GP modifier and OT should be requested using the GO modifier
- SLP services should be requested using the GN modifier

CSHCN Services Program Authorization Request for Initial Outpatient Therapy (TP1)

Please print or type requested information below.

Client Information

First name:	Last name:
CSHCN Services Program number: 9-_____-00	Date of birth:
Address/City/ZIP:	
Diagnoses:	

Evaluation Summary:

Date of evaluation: (A copy of the initial evaluation *must* be attached.)

Type of evaluation: ☐ Physical Therapy (PT) ☐ Occupational Therapy (OT) ☐ Speech Language Pathology (SLP)

Comments:

Service Request:

Indicate procedure code(s), modifier, the dates of service, and the frequency per week or month. Dates of service cannot exceed six months. If possible, end requested date(s) of service on the last day of a month.

Procedure Code	Modifier	From Date	To Date	Frequency/Week	Frequency/Month

Physician name:	Physician signature:	Date:
PT name:	PT signature:	Date:
OT name:	OT signature:	Date:
SLP name:	SLP signature:	Date:

Provider Information and Required Signature:

Provider name:	
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Provider contact name:	
Telephone number:	Fax number:
Address/City/ZIP:	
Signature of provider:	Date: