CSHCN Services Program Authorization and Prior Authorization Request for Hemophilia Blood Factor Products Form and Instructions

General Information

- Medical review is necessary for any diagnosis other than those listed in the *CSHCN Services Program Provider Manual* and for exceptions to any diagnosis restrictions. Complete this form when medical review is required for approval of blood factor products.
- Ensure the most recent version of the Authorization Request and Prior Authorization for Hemophilia Blood Factor Products 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, 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
12365-A Riata Trace Pkwy., Ste. 100
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:** The "Physician" or "Hospital" chapter in the current *CSHCN Services Program Provider Manual.*
- Physician prescription must accompany this form.

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 + 4
Diagnoses	Enter the diagnosis code relevant to the need for hemophilia blood factor products.

* Essential/Critical field

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Procedure Information

Field Description	Guidelines
Product name*	Enter the product name
Product manufacturer	Enter the product manufacturer name
National drug code (NDC)	Enter the NDC
HCPCS code*	Enter the Healthcare Common Procedure Coding System (HCPCS) code
Product quantity (per I.U.)*	Enter the product quantity

Prescribing Physician Information

Field Description	Guidelines
Requesting physician name*	Enter the requesting physician's name
NPI*	Enter the requesting physician's National Provider Identifier (NPI)
Telephone	Enter the physician's telephone number
Physician signature	Physician must sign in this field
Date	Enter the date the form is signed

Provider Information and Required Signature

Field Description	Guidelines
Rendering provider name*	Enter the rendering provider's name
Provider contact name (if any)	Enter the provider's contact name
Tax ID*	Enter the provider's TIN
NPI*	Enter the provider's NPI
Taxonomy code*	Enter the provider's taxonomy code
Benefit code*	Enter the CSN benefit code
Telephone	Enter the provider's telephone number
Fax	Enter the provider's fax number
Address/City/State/ZIP*	Enter the provider's address, city, state, and ZIP + 4
Provider signature	Provider must sign in this field
Date	Enter the date the form was signed

* Essential/Critical field

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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 **512-514-4222**.

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 priorauthorization request will be returned.*

Client Information:	
First name*:	Last name*:
CSHCN Services Program number*: 9-__________-00	Date of birth*:
Address/City/State/ZIP:	
Diagnoses:	

Product Information:
Product name*:
Product manufacturer:
National drug code (NDC):
HCPCS code*:
Product quantity (per I.U.)*:

Requesting Physician Information:	
I certify that the patient's medical condition is such that the treatment requested above is medically necessary.	
Requesting physician's name*:	
NPI*:	Telephone:
Physician signature:	Date:

Rendering Provider Information and Required Signature:		
Rendering provider name*:	Provider contact name (if any):	
Tax ID*:	NPI*:	
Taxonomy code*:	Benefit code*: **CSN**	
Telephone:	Fax:	
Street address*:		
City*:	State*:	ZIP + 4*:
Provider signature:		Date:

* Essential/Critical field