

THSteps Dental Mandatory 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.

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 any portion of this form is incomplete and/or missing any required documentation, it will be returned.

<p>Submit this form using TMHP's PA on the Portal. To access PA on the Portal, go to www.tmhp.com, click on "Providers," then "Prior Authorization" from the left hand menu. Then click "PA on the Portal" from the left hand menu and enter your Portal user name and password.</p>	<p>This form may also be submitted by mail to: Texas Medicaid & Healthcare Partnership THSteps Dental Prior Authorization Unit PO Box 204206 Austin TX 78720- 4206</p>			
<p>Client Name (Last, First, MI)*:</p>				
<p>Medicaid Number (PCN)*:</p>	<p>Date of Birth*:</p>			
<p><input type="checkbox"/> Restorative <input type="checkbox"/> Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)</p> <p>Note: Check all documentation submitted for review with the prior authorization request.</p>				
<p><input type="checkbox"/> Panorex</p>	<p><input type="checkbox"/> FM X-ray</p>	<p><input type="checkbox"/> Periapicals</p>	<p><input type="checkbox"/> Photos</p>	<p><input type="checkbox"/> Other Documentation</p>
<p><input type="checkbox"/> Orthodontic Services</p> <p>Note: Check all documentation submitted for review with the prior authorization request.</p>				
<p><input type="checkbox"/> Plaster cast models</p>	<p><input type="checkbox"/> E-models</p>	<p><input type="checkbox"/> HLD</p>	<p><input type="checkbox"/> Panorex</p>	<p><input type="checkbox"/> Cephalometric X-ray with tracing</p>
<p><input type="checkbox"/> FM X-ray</p>	<p><input type="checkbox"/> Photos</p>	<p><input type="checkbox"/> Other Documentation (please specify):</p>		
<p>Date of Service Diagnostic Tools Were Produced:</p>				
<p>Proposed Treatment Plan</p>				
<p>Procedure Code*</p>	<p>Tooth Number or Letter*</p>	<p>Surface</p>	<p>Charge</p>	
<p>Dentist's Certifications (to be completed by the rendering dentist)</p>				
<p>By checking the boxes below and signing this form:</p> <p><input type="checkbox"/> I certify all radiographs, photographs, and other documentation of medical necessity for the requested services are unaltered.*</p> <p><input type="checkbox"/> I certify I have discussed all treatment options with the client and parent or legal guardian, including the recommended surgical treatment plan. I have addressed the client's risks if the treatment plan is not followed to completion and explained the treatment plan should not be started if the family does not agree to this course of treatment.*</p> <p><input type="checkbox"/> I certify all primary dentition have been exfoliated (D8080).</p> <p>I certify I have one of the following designations from the Texas Board of Dental Examiners, or I meet the continuing education requirements to provide orthodontic services:</p> <p><input type="checkbox"/> Board certified or board eligible pediatric dentist.</p> <p><input type="checkbox"/> Board certified or board eligible orthodontist.</p> <p><input type="checkbox"/> General dentist attesting to completion of a minimum of 200 continuing dental education hours in orthodontics, only 8 hours can be online or self-instruction.</p> <p>Note: Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services, but documentation must be produced by the dentist during retrospective review.</p>				
<p>Signature of rendering dentist:</p>			<p>Date:</p>	
<p>Printed or typed name of dentist*:</p>		<p>Telephone:</p>	<p>Fax:</p>	
<p>Address*:</p>	<p>City:</p>	<p>State:</p>	<p>ZIP + 4*:</p>	
<p>Tax ID*:</p>	<p>NPI*:</p>	<p>Taxonomy*:</p>	<p>Benefit Code*:</p>	

*Essential/Critical field