Donor Human Milk 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**

Donor Human Milk Request Form

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.*

Donor Human Milk Request Form (Must be Reordered Every 180 Days)	
Client's Name*:	Client's Medicaid Number*:
Date of Birth*:	Client's Weight:
Please include the Donor Human Milk Request Form along with the CCP Prior Authorization Request Form. Parts A and B of the Donor Human Milk Request Form must be completed and copies retained in both the physician or allowed practitioner's and the milk bank's records. These forms and clinical records are subject to retrospective review.	
Part A	
The physician or allowed practitioner must keep up-to-date documentation of medical necessity and the signed written consent form in the child's clinical record to be considered for Medicaid reimbursement.	
The medical necessity for breast milk** is:	
Child's diagnosis:	
Date of last feeding trial:	
Reason donor milk is the only appropriate source of human milk for this client:	
**This information must be substantiated by written documentation in the clinical record of why the particular infant cannot survive and gain weight on any appropriate formula, such as an elemental formula or enteral nutritional product, other than donor human breast milk, and that a clinical feeding trial of an appropriate, nutritional product has been considered with each authorization.	
☐ The parent/guardian has signed and dated an informed consent that the risks and benefits of using banked donor human milk have been discussed with them.	

Dates of service requested:	From*:	To*:	Quantity Requested:
Requesting Physician or Allowed Practitioner's Signature:			Date:

Requesting Physician or Allowed Practitioner's Name*:		Fax Number:
License Number:	Tax ID:	NPI*:

* Essential/Critical field

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Part B			
The particular donor human milk bank adheres to quality guidelines consistent with the Human Milk Banking Association of North America, or other standards established by HHSC. ☐ Yes ☐ No			
Milk Bank Name*:		Milk Bank Fax:	
Milk Bank Street Address*:			
City:		State:	ZIP + 4*:
Milk Bank Representative's Signature:			Date:
Milk Bank Representative's Name:		Tax ID*:	
NPI*:	Taxonomy*:		Benefit Code*:

* Essential/Critical field