CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization and Authorization Request for Durable Medical Equipment (DME) form is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Incomplete **prior authorization** requests are denied. Requests are considered only when completed and received before the service is provided.
- 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 prior authorization and authorization form. Do not submit instruction pages.
- **Refer to:** Chapter "Durable Medical Equipment (DME)."

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
Diagnosis	Enter the diagnosis code relevant to the client's condition

Statement of Medical Necessity

Field Description	Guidelines
Item is to be:	Check the appropriate box
Client's height	Indicate the client's height
Client's weight	Indicate the client's weight
Description of item	Indicate the type of equipment
Equipment needed for	Check the appropriate box
Type or print physician's name*	Indicate the physician's name
Physician signature:	Physician must sign in this field
Date sign	Enter the date the form is signed

Equipment Information

Field Description	Guidelines
Brand Name or HCPCS Code*	Indicate the product's brand name or Healthcare Common Procedure Coding System (HCPCS) code
Model #	Indicate the product's model number
Item Description	Indicate the product's description
Quantity*	Indicate the quantity requested
HCPCS Price	Indicate the product's HCPCS price

Field Description	Guidelines
Cost/Retail Price	Indicate the product's cost or retail price
CSHCN Services Program Price	Indicate the product's CSHCN Services Program price
Serial #	Indicate the product's serial number
DOP	Indicate the product's date of purchase (DOP)?

Rendering Provider Information and Required Signature

Field Description	Guidelines
Orthotist/prosthetist name*	Enter the orthotist or prosthetist name
Signature	Orthotist or prosthetist must sign in this field
NPI*	Enter the provider's national provider identifier (NPI)
Taxonomy code*	Enter the provider's taxonomy code
Benefit code*	Enter CSN
Address/City/State/ZIP + 4*	Enter the orthotist's or prosthetist's address, city, state, and ZIP + 4
Rendering provider name*	Enter the vendor or provider's name
NPI*	Enter the provider's NPI
Taxonomy code*	Enter the provider's taxonomy code
Benefit code*	Enter CSN
Telephone	Enter the provider's telephone number
Fax	Enter the provider's fax number
Address/City/State/ZIP + 4*	Enter the provider's address, city, state, and ZIP + 4
Signature of DME provider	DME provider must sign in this field
Date	Enter the date the form is signed

Additional Information for Gait Trainer Requests

Field Description	Guidelines
Child's condition/functional level	Indicate the child's condition and functional level
Is the child expected to be ambulatory, and if so, when?	Indicate "yes" or "no" and date
Specify the time, frequency, and location where the gait trainer will be used	Indicate the time, frequency and location that the gait trainer will be used
Specify the length of time the gait trainer is expected to be needed	Indicate the length of time that the gait trainer is expected to be needed
Specify the growth potential of the equipment	Indicate the growth potential of the equipment
Therapist's name typed or printed	Enter therapist's name
Telephone	Enter therapist's telephone number
Fax	Enter therapist's fax number
Therapists signature	Therapists must sign in this field
Date	Enter the date the form is signed

Additional Information for Prone or Supine Stander Requests

Field Description	Guidelines
Child's condition/functional level	Indicate child's condition and functional level
Specify anticipated benefits expected from the stander	Indicate anticipated benefits expected from the stander
Frequency and amount of the child's standing program (e.g., 45 minutes, 3 X daily)	Indicate frequency and amount of time of the child's standing program
Frequency the stander will be used at home	Indicate the frequency that the stander will be used at home
Length of time the stander is	Indicate the length of time the stander is expected to be needed

Field Description	Guidelines
expected to be needed (growth potential)	
Therapist's name typed or printed	Enter therapist's name
Telephone	Enter therapist's telephone number
Fax	Enter therapist's fax number
Therapists signature	Therapists must sign in this field
Date	Enter the date the form is signed

Additional Information for Special Needs Car Seat or Travel Restraint Requests

Field Description	Guidelines
Head control	Check the appropriate box
Trunk control	Check the appropriate box
Equipment requested	Indicate requested equipment
Name of certified installer	Enter the name of the certified installer
Name of title of person completing form	Enter the name and title of person completing the form
Date	Enter the date the form is completed
Telephone	Enter the telephone number for the person completing the form

Additional Information for Hospital Crib/Enclosed Bed Requests

Field Description	Guidelines
Medical needs, developmental level, and functional skills	Describe requested information
Describe any other less-restrictive devices which have been used, the length of time used and why ineffective	Describe requested information
Describe why a regular child's crib, regular bed, or standard hospital bed cannot be used	Describe requested information
Name of therapist or doctor typed or printed	Enter the name of the therapist or doctor
Telephone number	Enter the therapist or doctor's telephone number
Fax number	Enter the therapist or doctor's fax number
Name and title of person completing form	Enter the name and title of person completing the form
Date	Enter the date the form is completed
Telephone number	Enter the telephone number for the person completing the form

Additional Information for Electric Hospital Bed Requests

Field Description	Guidelines
Is the client able to assist with his/her personal care and can physically operate the controls?	Indicate "yes" or "no"
Describe why the caretaker is physically limited and cannot crank a manual bed	Describe requested information
Describe the medical necessity why the client may require quick adjustment of the bed for medical issues	Describe requested information
Explain why a standard bed or crib will not meet the client's need.	Provide an explanation addressing why a standard bed or crib will not meet the client's need.
Name of therapist or doctor	Enter the name of the therapist or doctor

Field Description	Guidelines
typed or printed	
Telephone	Enter the therapist or doctor's telephone number
Fax	Enter the therapist or doctor's fax number
Name and title of person completing form	Enter the name and title of person completing the form
Date	Enter the date the form is completed
Telephone	Enter the telephone number for the person completing the form

Additional Information for Hygiene Equipment Requests

Field Description	Guidelines
Equipment requested	Indicate the requested equipment
Length of time needed	Indicate the length of time needed
Is this replacement equipment	Indicate "yes' or "no"
If replacement, why existing equipment cannot be used	Indicate why existing equipment cannot be used. (for replacements only)
Document client's anticipated independence with the equipment (Required for rental or purchase requests)	Document client's anticipated independence with the equipment (Required for rental or purchase requests)
Tone	Check the appropriate box
Head control	Check the appropriate box
Trunk control	Check the appropriate box
Upper extremity	Check the appropriate box
Lower extremity	Check the appropriate box
Transfers	Check the appropriate box
Name and title of person completing form	Enter the name and title of person completing the form
Date	Indicate the date
Telephone number	Enter the telephone number of the person completing the form

Additional Requirements

Special Needs Car Seat or Travel Restraint Requests

- A photocopy of the training certification of the individual installing the car seat must accompany each request for authorization to be considered for reimbursement by the CSHCN Services Program.
- Providers must include the name of the individual installing the car seat on this form, or providers must include documentation with the form indicating that the top tether was factory installed by the vehicle's manufacturer before vehicle purchase.
- Providers must keep a statement on record that is signed and dated by the child's parent or guardian and the provider stating that a top tether was installed by a manufacturer-trained provider in the automobile used to transport the child; parent training in the correct use of the car seat was provided by a manufacturer-trained provider; and the parent demonstrated the correct use of the car seat to a manufacturer-trained provider.
- Requests for authorization of a travel restraint must document the medical necessity of transporting the child in a supine position.

Prone or Supine Stander Requests

- Provider must submit documentation indicating the plan for training the school and home caregivers in the correct and safe use of the equipment.

Gait Trainer Requests

- Provider must submit documentation indicating the plan for training the school and home caregivers in the correct and safe use of the equipment.

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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 TMHPPortal 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 foradditional 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 *CSHCN Services Program Provider Manual*.

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 CSHCN Services Program enrollment and/or personal exclusion from the CSHCN Services Program.

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 CSHCN Services Program Provider Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) (page 2 of 6)

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*

For specialized seating or custom wheelchair purchase requests, also complete the 5-page CSHCN Services Program Wheelchair Seating Evaluation Form. Please print or type requested information below.

Client Information

First name*:	Last name*:
CSHCN Services Program number*: 9-____________________-00	Date of birth*:
Address/City/State/Zip	
Diagnosis:	

Statement of Medical Necessity – Required for ALL equipment requests

Item(s) is to be: ☐ Purchased ☐ Modified ☐ Repaired ☐ Rented and if rental, service date ____________________

Client's height:	Client's weight:	Description of Item:

Equipment needed for: ☐ Lifetime ☐ < 6 months ☐ > 6 months ☐ > 1 year ☐ Other ____________________

I certify that the patient's medical condition is such that all equipment requested above is medically necessary. (Some items may require additional medical justification.) Refer to CSHCN Services Program Provider Manual Chapter 17.7, Reimbursements, page 17-25.

Type or print physician's name*:	
Physician's signature:	Date signed:

Equipment Information

Must be completed and signed by the *vendor*. The equipment description and pricing information indicated below must be complete. For manually priced custom DME requests, attach manufacturer's price sheet(s) for each item.

Equipment Description				**Pricing Information**		
Brand Name or HCPCS Code*	**Model #**	**Item Description**	**Quantity***	**HCPCS Price**	**Cost/Retail Price**	**CSHCN Services Program Price**
			Total			

Wheelchair modifications or repairs list the make/model:	**Make:**	**Model:**
Serial #	**DOP:**	

Provider Information and Required Signature

Orthotist/prosthetist name*:	Signature:	
Orthotist/prosthetist contact name:		
NPI*:	Taxonomy Code:	Benefit Code:
Street Address*:		
City:	State:	ZIP + 4*:
Rendering Provider Name:		Tax ID:
NPI*:	Taxonomy Code:	Benefit Code:

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This form provides additional lines for requests that contain more than 5 items.

Telephone:		Fax:	
Street Address*:			
City:	State:		ZIP + 4*:
Signature of DME provider:		Date:	

Equipment Description			Quantity Information		Pricing Information		
Brand Name or HCPCS Code*	Model #	Item Description	Quantity*	Beyond Quantit y Limit?	HCPCS Price	Cost/Retail Price	CSHCN Services Program Price
				Total			

CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) (page 4 of 6)

Required for gait trainer and prone or supine stander requests, in addition to page 2.

Client Information	
First name*:	Last name*:
CSHCN Services Program number*: 9-____________________-00	

Additional Information for Gait Trainer Requests	
Child's condition/functional level:	
Is the child expected to be ambulatory, and if so, when?	
Specify the time, frequency, and location where the gait trainer will be used:	
Specify the length of time the gait trainer is expected to be needed:	
Specify the growth potential of the equipment:	
Therapist's name typed or printed:	
Telephone:	Fax:
Therapist's signature:	Date:

Additional Information for Prone or Supine Stander Requests	
Child's condition/functional level:	
Specify anticipated benefits expected from the stander:	
Frequency and amount of time of the child's standing program (e.g., 45 minutes, 3 x daily):	
Frequency the stander will be used at home:	
Length of time the stander is expected to be needed (growth potential):	
Therapist's name typed or printed:	
Telephone:	Fax:
Therapist's signature:	Date:

CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) (page 5 of 6)

Required for car seat or travel restraint, hospital crib/enclosed bed, or electronic hospital bed requests, in addition to page 2.

Client Information			
First name*:		Last name*:	
CSHCN Services Program number*: 9-____________________-00			
Additional Information for Special Needs Car Seat or Travel Restraint Requests			
Head control:	☐ Good	☐ Fair	☐ Poor
Trunk control:	☐ Good	☐ Fair	☐ Poor
Equipment requested:			
Name of certified installer:			
Name and title of person completing form:			
Date:		Telephone:	
Additional Information for Hospital Crib/Enclosed Bed Requests			
Medical needs, developmental level, and functional skills:			
Describe any other less-restrictive devices which have been used, the length of time used, and why ineffective:			
Describe why a regular child's crib, regular bed, or standard hospital bed cannot be used:			
Name of therapist or doctor typed or printed:			
Telephone:		Fax:	
Name and title of person completing form:			
Date:		Telephone:	
Additional Information for Electric Hospital Bed Requests			
Explain why a standard bed or crib will not meet the client's need.			
Is the client able to assist with his/her personal care and can physically operate the controls? Answer: Yes______No_____. If No, please answer the following two questions:			
1) Describe why the caretaker is physically limited and cannot crank a manual bed.			
2) Describe the medical necessity why the client may require quick adjustment of the bed for medical issues.			
Name of therapist or doctor typed or printed:			
Telephone:		Fax:	
Name and title of person completing form:			
Date:		Telephone:	

CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) (page 6 of 6)

Required for hygiene equipment requests, in addition to page 2.

Client Information				
First name*:		Last name*:		
CSHCN Services Program number*: 9-____________________-00				
Additional Information for Hygiene Equipment Requests				
Equipment requested:				
Length of time needed:		Is this replacement equipment?	☐ Yes	☐ No
If replacement, why existing equipment cannot be used:				
Client's anticipated independence with the requested equipment (Required for rental and purchase): ☐ Independent ☐ Minimum Assistance ☐ Moderate Assistance ☐ Maximum Assistance ☐ Dependent				
Tone:	☐ High	☐ Low	☐ Fluctuating	☐ Absent
Head control:	☐ Good	☐ Fair	☐ Poor	
Trunk control:	☐ Good	☐ Fair	☐ Poor	
Upper extremity:	☐ Good	☐ Fair	☐ Poor	
Lower extremity:	☐ Good	☐ Fair	☐ Poor	
Transfers:	☐ Dependent	☐ Independent		
Name and title of person completing form:				
Date:		Telephone:		