CSHCN Services Program Prior Authorization Request for Diabetic Equipment and Supplies Form

General Information

- Ensure the most recent version of the Prior Authorization Request for Diabetic Equipment and Supplies Form is submitted. The form is available on the TMHP website atwww.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 form. Do not submit instruction pages.
- **Refer to**: The "Diabetic Equipment and Supplies" chapter in the current *CSHCN Services Program Provider Manual*.

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 + 4	Enter the client's address, city, state, and ZIP + 4
Diagnoses	Enter the diagnosis code(s) relevant to the diabetic equipment and supplies

Statement of Medical Necessity

Field Description	Guidelines
HCPCS Code / Service Description*	Check the appropriate procedure code being requested
Most recent Hb/A1C results?	Indicate the most recent Hb/A1 C results
Date	Indicate the date of the most recent Hb/A1C results
Check applicable boxes	Check the applicable box

Requesting Provider Information and Signature

Field Description	Guidelines
Requesting Provider Name*	Enter the provider's name
Requesting Provider Signature	Provider must sign in this field
Date	Enter the date the form is signed
NPI*	Enter the provider's national provider identifier (NPI)

Rendering Provider Information and Required Signature

Field Description	Guidelines
Rendering provider name*	Enter the provider's name
Contact person	Enter the contact person
Tax ID*	Enter the provider's Tax ID
NPI*	Enter the provider's national provider identifier (NPI)
Taxonomy code*	Enter the provider's taxonomy code
Benefit code*	Enter CSN
Telephone number	Enter the provider's telephone number
Fax number	Enter the provider's fax number

CSHCN Services Program Prior Authorization Request for Diabetic Equipment and Supplies Form

Field Description	Guidelines
Address/City/ZIP + 4*	Enter the provider's address, city, and ZIP + 4
Provider signature	Provider must sign in this field
Date	Enter the date the form is signed

CSHCN Services Program Prior Authorization Request for Diabetic Equipment and Supplies 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 **512-514-4222**.

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 *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 Request for Diabetic Equipment and Supplies 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.*

Client Information

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

Statement of Medical Necessity

HCPCS Code*	Service Description	Quantity*/Frequency*

Most recent Hb/A1C results? (*Please attach recent history of glucose levels*.)	Date of most recentHb/A1C results:

FOR RENTAL OF THE EXTERNAL INSULIN PUMP:

For clients diagnosed with Type 1 or Type 2 diabetes, please attach the supporting clinical documentation and indicate least two of the following conditions that apply:

- ☐ Initial rental for three months
- ☐ Elevated glycosylated hemoglobin level (HbA1c) > 7.0%
- ☐ History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
- ☐ History of severe glycemic excursions with wide fluctuations in blood glucose
- ☐ History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness

By signing this form, the requesting provider attests that:
The client and or caregiver possess the following:

- The cognitive and physical abilities to use the recommended insulin pump treatment regimen.
- The willingness to support the use of the external insulin pump.
- A training/education plan will be completed prior to the initiation of pump therapy.
- The client and/or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating insulin pump therapy with their current treatment regimen for ambient glucose control.

FOR PURCHASE OF THE EXTERNAL INSULIN PUMP:

An external insulin pump may be considered for prior authorization of purchase after it has been rented for a 3-month trial and all of the following documentation is provided:

- ☐ Three-month trial successfully completed
- ☐ The training/education plan has been completed
- ☐ The pump is the appropriate equipment for the specific client
- ☐ The client is compliant with the use of the pump

CSHCN Services Program Prior Authorization Request for Diabetic Equipment and Supplies Form

HCPCS Code*	Service Description	Quantity*/Frequency*

Most recent Hb/A1C results? (Please attach recent history of glucose levels.)	Date of the most recentHb/A1C results:

FOR CONTINUOUS GLUCOSE MONITOR DEVICE AND SUPPLIES:

Available for clients diagnosed with Type 1 diabetes ONLY. Please attach the supporting clinical documentation and indicate at least two of the following conditions that apply:

- ☐ Elevated glycosylated hemoglobin level (HbA1c) > 7.0%
- ☐ History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
- ☐ History of severe glycemic excursions with wide fluctuations in blood glucose
- ☐ History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness
- ☐ History of diabetic ketoacidosis

By signing this form, the requesting provider attests that: The client and or caregiver possess the following:

- The cognitive and physical abilities to use the recommended continuous glucose monitor regimen.
- An understanding of cause and effect.
- The ability to learn to use the device, and to hear and view alerts and respond appropriately
- The willingness to support the use of the continuous glucose monitor (CGM).
- A training/education plan will be completed prior to the initiation of continuous glucose monitor therapy.
- The client and/or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating continuous glucose monitor therapy with their current treatment regimen for glucose control.

Requesting Provider Information and Signature

Requesting provider name*:	
Requesting provider NPI*:	
Requesting provider signature:	Date:

Rendering Provider Information and Required Signature

Rendering provider name*:	Contact person:	
Tax ID*:	NPI*:	
Taxonomy code*:	Benefit code*: **CSN**	
Telephone:	Fax:	
Street Address*:		
City:	State:	ZIP + 4*:
Provider signature:		Date: