CSHCN Services Program
Instructions for Prior Authorization Request for Hospice Services

General Information

- Ensure the most recent version of the Prior Authorization Request for Hospice Services 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 form. Do not submit instruction pages.
- **Refer to:** The "Hospice" 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	Enter the client's address, city, state, and ZIP
Hospice diagnoses	Enter the diagnosis code(s) relevant to the need for the hospice services

Requested Services

Field Description	Guidelines
Start of care date (mm/dd/yy)*	Enter the start of care date
End of care date (mm/dd/yy)*	Enter the end of care date
Type of hospice care	Enter the type of hospice care (routine home, continuous home, inpatient hospice, respite)
Describe direct care to be provided	Describe the direct care to be provided such as durable medical equipment (DME), supplies, and medications anticipated for the care of the client

Provider Information and Required Signatures

Field Description	Guidelines
Hospice Provider	
Hospice provider name*	Enter the name of the hospice provider
Tax ID*	Enter the hospice provider's Tax Identification Number (TIN)
NPI*	Enter the hospice provider's NPI

Field Description	Guidelines
Taxonomy code*	Enter the hospice provider's taxonomy code
Benefit code*	Enter CSN
Telephone	Enter the hospice provider's telephone number
Fax	Enter the hospice provider's fax number
Address/City/State/ZIP*	Enter the hospice provider's address, city, state, and ZIP + 4
Authorized signature	Authorize person must sign in this field
Date	Enter the date the form is signed
Requesting Physician	
Requesting physician name*	Enter the name of the requesting physician
NPI*	Enter the requesting physician's NPI
Telephone	Enter the requesting physician's telephone number
Fax	Enter the requesting physician's fax number
Referring physician's signature	Requesting physician must sign in this field
Date	Enter the date the form is signed

Additional Requirements

- Hospice providers must submit the "CSHCN Services Program Prior Authorization Request for Hospice Services form" or the provider's plan of care (POC) if it includes:
    - The same information as the "CSHCN Services Program Prior Authorization Request for Hospice Services" form.
    - The hospice provider's and referring physician's signatures.
- Prior authorization requests for hospice may be granted for up to a maximum of six months.
- If the client requires hospice care beyond the initial six-month period, authorization for additional six-month periods may be considered with a new request that includes the following documentation:
    - An updated "CSHCN Services Program Prior Authorization Request for Hospice Services" form or a POC that includes the same information as the CSHCN Services Program Prior Authorization Request for Hospice Services form and the hospice provider's and physician's signatures.
    - An updated description of all direct care, durable medical equipment, supplies, and medications anticipated for the care of the client.

CSHCN Services Program
Prior Authorization Request for Hospice Services

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 Hospice Services

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:				
Hospice diagnoses:				
Requested Services:				
Start of care date (mm/dd/yy)*:		End of care date (mm/dd/yy)*:		
Type of hospice care:	☐ Routine home	☐ Continuous home	☐ Inpatient hospice	☐ Respite
Describe direct care to be provided. Include durable medical equipment, supplies, and medications anticipated for the care of the client:				

Provider Information and Required Signatures:			
Hospice Provider			
Rendering hospice provider name*:			
Hospice contact name:			
Tax ID*:	NPI*:	Taxonomy code*:	Benefit code*: **CSN**
Telephone:		Fax:	
Street address*:			
City:		State:	ZIP + 4*:
Authorized signature:			Date:
Requesting Physician			
Requesting physician name*:			
Requesting physician contact name:			
Requesting physician NPI*:			
Telephone:		Fax:	
I certify that the client is terminally ill with a medical prognosis of six months or less to live, if the illness runs the normal course.			
Requesting physician's signature:			Date: