CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only Instructions

General Information

- Use the most recent version of the Prior Authorization Request for Inpatient Hospital Admission – For Use by Facilities Only form. Updated forms are available on the TMHP website at www.tmhp.com.
- **All sections of this form must be completed.**
- Incomplete ***prior authorization*** requests are denied and are considered only when completed and received before the service is provided.
- Information must be printed or typed.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, which is available 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 Hospital section in the current *CSHCN Services Program Provider Manual*.

Prior Authorization Request Submitter Certification

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
Diagnoses	Enter the diagnosis code(s) and description(s) relevant to the need for the inpatient hospital admission
Other insurance information (check each that applies)	Indicate whether the client has other insurance, and enter the client's other insurance type (private, Medicare, or Medicaid)
Insurance Type	Enter the insurance type
Insurance Carrier	Enter the insurance carrier
Insurance ID	Enter the insurance ID

Type of admission and medical necessity

Field Description	Guidelines
Emergent admission from:	Check the appropriate boxes to indicate where the patient was admitted from.
Scheduled Surgery	Check this box for admissions related to a scheduled surgery. Enter the surgical procedures codes requested and the surgeon's name, TPI, NPI, taxonomy code and benefit code.

Field Description	Guidelines
Scheduled chemotherapy or other	Check this box for admissions related to scheduled chemotherapy or other scheduled services. For other services specify the type of service in the space provided.
Document medical necessity	Document medical necessity for each service that pertains to the hospital stay as needed. Attach additional pages as needed.

Admission information

Field Description	Guidelines
Date of admission*	Enter the date of admission
Anticipated date of discharge*	Enter the anticipated date of discharge. **Note:** *A date **must** be entered in this field. If a date is not included, the request may be rejected or denied.*
Requesting physician's name*	Enter the requesting physician's name
NPI*	Enter the requesting physician's NPI
Taxonomy code	Enter the requesting physician's taxonomy code
Benefit code	Enter the CSN benefit code
Address/City/State/ZIP*	Enter the requesting physician's address, city, state, and ZIP + 4

Hospital information and authorized required signature

Field Description	Guidelines
Rendering hospital name*	Enter the hospital name
Hospital contact name	Enter the hospital's authorized contact name
Tax ID*	Enter the hospital's Tax Identification Number (TIN)
NPI*	Enter the hospital's NPI
Taxonomy code*	Enter the hospital's taxonomy code
Benefit code*	Enter the CSN benefit code
Telephone number	Enter the hospital's telephone number
Fax number	Enter the hospital's fax number
Address/City/State/ZIP*	Enter the hospital's address, city, state, and ZIP + 4
Authorized signature	Authorized person must sign in this field
Date	Enter the date the form is signed

Additional Requirements

Prior Authorization request for inpatient hospital admissions:

- Friday and weekend admissions may be prior authorized on the following Monday (or in the case of a holiday, on the next business day) when an emergency exists or when the required medical services will not be delayed due to the timing of the admission.
- All prior authorization request forms must be complete and must include either the surgeon's or the attending physician's name and provider identifier on the authorization request form. These physicians and the hospital must be actively enrolled in the CSHCN Services Program to obtain prior authorization.
- If a request for prior authorization of an inpatient hospitalization is received for a CSHCN Services Program-enrolled client from a nonenrolled provider, the request is denied. If that provider subsequently enrolls as a CSHCN Services Program provider and submits a claim for these previously denied services within the 95-day claims filing deadline, then the claim may be considered for reimbursement based on the medical necessity of the services. If a provider does not complete the request, or if a request for prior authorization was not received from an enrolled provider, then the claim cannot be considered for payment and is denied. All providers must be enrolled in order to receive reimbursement.

- If prior authorization for a nonemergency inpatient admission is not requested and approved before the admission, the claim will be denied.

Prior Authorization request for emergency inpatient hospital admissions:

- Prior authorization requests for emergency admissions must be completed by the next working day after the admission date for coverage of the entire stay.
- Emergency admissions are defined as those that are medically necessary for same day admission from the emergency room or from a provider's office or clinic. If an authorization request is made later than the next business day, it will be denied. All applicable information must accompany the request documenting the emergent conditions that necessitated the inpatient admission.
- If the initial request for an emergency hospital admission is received timely, and denied for incomplete or inaccurate information, the provider may correct and resubmit the PA request. The corrected request is a *one-time resubmission* only and must be received by the next business day following the denial of the initial request. If the corrected request is received by the next business day, but still contains incomplete or inaccurate information, the request will not be eligible for a second resubmission and will be denied for the entire hospital stay. Corrected requests received after the next business day following the initial denial will be denied for the entire hospital stay.
- Authorization will be granted if the admission criteria are met. Requests for extensions are no longer necessary.

For stem cell transplants, refer to the *CSHCN Services Program Provider Manual* for specific criteria that must accompany each request.

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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 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

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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:		
Other insurance information (check *each* that applies): ☐ None ☐ Yes	If Yes: ☐ Private ☐ Medicare ☐ Medicaid	
Insurance ID:	Insurance Type:	
Insurance Carrier:		

Type of admission and medical necessity

Emergent admission from:	☐ Emergency Room ☐ Dr. Office ☐ Clinic ☐ Specialty Clinic - Type: _____	
☐ Scheduled surgery	Surgical procedures requested (include CPT code[s]):	
	Surgeon's name:	
	Surgeon's Tax ID:	Surgeon's NPI:
	Taxonomy code:	Benefit code: **CSN**
☐ Scheduled Chemotherapy or Other	Specify:	
Document medical necessity (attach additional pages as needed):		

Admission Information

Date of admission*:	Anticipated date of discharge*:	
Requesting physician's name*:		
NPI*:	Taxonomy code:	Benefit code: **CSN**
Street address*:		
City:	State:	ZIP + 4*:

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Client Information			
First name*:	Last name*:		
CSHCN Services Program number*: 9-_____-00			
Rendering Hospital Information and Authorized Required Signature			
Rendering hospital name*:			
Hospital contact name:			
Tax ID*:	NPI*:		
Taxonomy code*:	Benefit code*: **CSN**		
Telephone:	Fax:		
Street address*:			
City:	State:	ZIP + 4*:	
Authorized signature:		Date:	