CSHCN Services Program Prior Authorization Request for Medical Nutritional Products Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Medical Nutritional Products 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 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 **512-514-4222**.
- Submit only the prior authorization form. Do not submit instruction pages.
- **Refer to:** The "Medical Nutrition Services" 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
Diagnoses	Enter the diagnosis code(s) relevant to the need for additional medical nutritional products

* Essential/Critical field

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Nutritional Products

Field Description	Guidelines
Name of product	Enter the full name of the nutritional product that listed on the product label
Procedure Code*	Enter the procedure code for the nutritional product being requested
Number of containers per day*	Indicate the total number of cans/containers ingested per day
Ounces/ml Per Container	Enter the volume of container in ounces or ml include unit type
Total caloric intake from all sources	Enter the total caloric intake from all sources
Total caloric intake from formula	Enter the total caloric intake from formula
Why can this client not be maintained on an age appropriate diet?	Document medical necessity for nutritional products. Explain why the client cannot be maintained on an age appropriate diet
Current height, Current weight, and BMI	Enter the client's most recent height, weight, and BMI
Attach growth charts or history (weight only if over 18 years of age)	Attach supporting documentation indicating the client's height, weight, and BMI history. Height history is not required for clients over age 18

Thickener

Field Description	Guidelines
Does the client have a diagnosis of dysphagia?	Answer question about whether the client has a diagnosis of dysphagia yes or no
Has the client had a swallow study?	Answer question about whether the client has had a swallow study yes or no
Recommended thickness from recent swallow study.	Answer the question with mark at ordered thickness

Relizorb

Field Description	Guidelines
Diagnosis of Exocrine Pancreatic Insufficiency and Cystic Fibrosis	Answer the question does the client have a diagnosis of Exocrine Pancreatic Insufficiency and Cystic Fibrosis with a check mark at yes or no
Type of request	Put a check mark by initial or renewal for type of request
Does the client utilize an enteral feeding pump for overnight feedings?	Answer question if client utilizes an enteral feeding pump for overnight feedings with a mark at yes or no
Amount of formula client receives during overnight feedings	Answer the question about the number of mL the client receives during overnight feedings with a specific number
Is client's formula compatible?	Answer question if the client's formula is compatible with RELiZORB with mark at yes or no
Number of cartridges requested per day	Answer the question about the number of cartridges per day with a mark at 1 or 2

* Essential/Critical field

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Requesting Physician Information and Required Signature

Field Description	Guidelines
Requesting physician's name*	Enter the name of the physician requesting the nutritional product
NPI*	Enter the requesting physician's National Provider Identifier (NPI)
Telephone	Enter the prescribing physician's telephone number
Fax	Enter the prescribing physician's fax number
Signature	Prescribing physician must sign in this field
Date	Enter the date the form is signed

Rendering Provider Information

Field Description	Guidelines
Rendering provider name*	Enter the name of the provider rendering the medical nutritional product
Telephone	Enter the rendering provider's telephone number
Fax	Enter the rendering provider's fax number
Address*	Enter the rendering provider's full address with ZIP + 4 code
Taxonomy code*	Enter the rendering provider's taxonomy code
Benefit Code*	Enter the rendering provider's benefit code
Tax ID*	Enter the dispensing provider's tax payer ID number
NPI*	Enter the rendering provider's national provider identifier (NPI)

* Essential/Critical field

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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 *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**

CSHCN Services Program Prior Authorization Request for Medical Nutritional Products 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:	

Nutritional Products

Procedure Code*	Full Name of the Product	Number of Containers Per Day*	Ounces/ml Per Container

Total daily caloric intake from all sources:	Total daily caloric intake from formula:
Why can this client not be maintained on an age appropriate diet?	

Current height**:	Current weight**:	BMI**:

****Attach growth charts or history (weight only if over 18 years of age)**

Thickener

Does the client have a diagnosis of dysphagia? ☐ Yes ☐ No	Has the client had a swallow study? ☐ Yes ☐ No
Recommended thickness from swallow study. Thin____ Nectar____ Honey____ Pudding____	

Relizorb

Does the client have a diagnosis of Exocrine Pancreatic Insufficiency and Cystic Fibrosis? ☐ Yes ☐ No	
Initial Request ☐	Renewal Request ☐
Does the client utilize an enteral feeding pump for overnight feedings? ☐ Yes ☐ No	
Amount of formula (mL) client receives during overnight feedings:	
Does the client utilize a compatible formula with RELiZORB? ☐ Yes ☐ No	
Number of cartridges requested per day (maximum of 2 cartridges per day for more than 500 mL of formula per day) ☐ 1 ☐ 2	

* Essential/Critical field

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Requesting Physician Information and Required Signature		
Requesting physician's name (printed or typed)*:		
Contact name:		
NPI*:	Telephone:	Fax:
Requesting physician signature:		Date:

Rendering Provider Information			
Rendering provider name (printed or typed)*:			
Telephone:		Fax:	
Street address*:			
City*:		State*:	ZIP + 4*:
Tax ID*:	NPI*:	Taxonomy*:	Benefit Code*: **CSN**

* Essential/Critical field