CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions

General Information

- Ensure the most recent version of the Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons 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 "Hospital" 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 + 4
Other insurance information	Enter any other insurance information
Insurance type/carrier	Enter the insurance type/carrier
Insurance ID number:	Enter the insurance ID number
Diagnoses	Enter the diagnosis code(s) relevant to the need for outpatient surgery

Surgery Information

Field Description	Guidelines
Surgical procedure(s) requested*	Enter the surgical procedure(s) being requested (per CPT code)
Anticipated date of outpatient/day surgery*	Enter the anticipated date of outpatient/day surgery

Surgeon's Information

Field Description	Guidelines
Requesting surgeon's name*	Enter the surgeon's name*
Benefit code	Enter the CSN benefit code
Address/City/State/ZIP*	Enter the surgeon's address, city, state, and ZIP + 4
Tax ID*	Enter the surgeon's Tax Identification Number (TIN)
NPI*	Enter the surgeon's National Provider Identifier (NPI)
Taxonomy*	Enter the surgeon's taxonomy code

Facility Information and Authorized Signature

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

Freestanding Surgical Center Information

(This section must only be completed for surgery performed in a freestanding facility.)

Field Description	Guidelines
Indicate client's physical status	Check the appropriate ASA level
Indicate the client's condition	Check the appropriate box to indicate the client's condition. ***Note:*** *If the client's condition is P3, P4, P5, or P6, services may be authorized in a hospital-based ambulatory surgical center, but not in a freestanding surgical center. Descriptions follow.*

Additional Requirements

Prior Authorization request for outpatient surgery services:

- Some outpatient surgery procedures have specialty team requirements.
- Contact TMHP-CSHCN Services Program or refer to the *CSHCN Services Program Provider Manual* for more information.
- Please include additional information as applicable (documentation for procedures, medical necessity, etc.).
- For rhizotomy and craniotomy for anterior temporal lobectomy, see the Provider Manual for specific criteria that must accompany the request for any of these procedures.

CSHCN Services Program Prior Authorization and Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons

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:		
Other insurance information (check *each* that applies)	☐ No ☐ Yes	If Yes: ☐ Private ☐ Medicare ☐ Medicaid
Insurance type/carrier:	Insurance ID number:	
Diagnoses:		

Surgery Information
Surgical procedure(s) requested (CPT code)*:
Anticipated date of outpatient/day surgery*:

Surgeon's Information		
Requesting surgeon's name*:		Benefit code*: **CSN**
Street address*:		
City:	State:	ZIP + 4*:
Tax ID*:	NPI*:	Taxonomy*:

Facility Information and Authorized Signature		
Rendering facility name*:		Benefit code: **CSN**
Street address*:		
City:	State:	ZIP + 4*:
Tax ID*:	NPI*:	Taxonomy*:
Facility's contact name (if any):		
Telephone:	Fax:	
Authorized signature:		Date:

Freestanding Surgical Center Information	
This section must only be completed for surgery performed in a freestanding facility. If freestanding surgical center, indicate patient's physical status (ASA level) below.	
☐ ASA I/P1	Normal healthy patient
☐ ASA II/P2	Patient with mild systemic disease
If the patient's condition is P3, P4, P5, or P6, services may be authorized in a hospital-based ambulatory surgical center, but not in a freestanding surgical center. Descriptions follow.	
☐ ASA II/P3	Patient with severe systemic disease
☐ ASA II/P4	Patient with severe systemic disease which is a constant threat to life
☐ ASA II/P5	Moribund patient who is not expected to survive without the operation
☐ ASA II/P6	Declared brain-dead patient whose organs are being removed for donor organs.