Residential Withdrawal Management Authorization Request 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. 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. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To submit by fax, send to **512-514-4211**.

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

Residential Withdrawal Management Authorization Request Form

Attach a comprehensive assessment of client history, treatment plan, and/or progress notes to support medical necessity.

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.*

A. Identifying Information

Client Information

Client Name (*Last, First, M.I.*)*:		Date of Birth*:	
Medicaid Number*:		Age:	Sex:
Date of Admission:	Time:	Date of Submission:	

Chemical Dependency Treatment Facility Information

Rendering Facility Name*:	Contact Person:	
Street Address*:		
City:	State:	ZIP + 4*:
Telephone:	Fax:	
Tax ID*:	NPI*:	
Benefit Code*:	Taxonomy*:	

B. Factors for Admission (for admission, complete all sections except section E)

Impaired neurological functions / altered mental state as evidenced by	Failure of two previous treatment episodes of outpatient withdrawal management ☐ Yes ☐ No
Extreme depression ☐ Yes ☐ No	Client has a seizure disorder or history of seizures during substance withdrawal ☐ Yes ☐ No
Disorientation to self ☐ Yes ☐ No	Presence of any presumed new asymmetric and/or focal findings ☐ Yes ☐ No
Alcoholic hallucinosis ☐ Yes ☐ No	Unstable vital signs combined with a history of past acute withdrawal syndromes ☐ Yes ☐ No
Toxic psychosis ☐ Yes ☐ No	Clinical condition (e.g., agitation, intoxication, or confusion) which prevents satisfactory assessment ☐ Yes ☐ No
Altered level of consciousness ☐ Yes ☐ No	Serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension ☐ Yes ☐ No

C. Medical Complications (e.g., GI bleeding, gastritis, severe anemia, malnutrition, hepatitis, diabetes mellitus [uncontrolled], cardiac disease, hypertension)

* Essential/Critical field

Residential Withdrawal Management Authorization Request Form

D. Psychiatric Symptoms

Severe neurological and/or psychological symptoms ☐ Yes ☐ No

Danger to self or others ☐ Yes ☐ No

Mental confusion and/or fluctuating orientation ☐ Yes ☐ No

E. Continued Stay (complete only sections A, E, F, G, and H if additional withdrawal management days are required)

Unstable vital signs ☐ Yes ☐ No

Continued disorientation ☐ Yes ☐ No

Abnormal laboratory findings related to chemical dependency ☐ Yes ☐ No

Cognitive deficit related to withdrawal affecting the client's ability to recognize alcohol/drug use as a problem ☐ Yes ☐ No

Laboratory finding that a drug has not sufficiently cleared the client's system ☐ Yes ☐ No

Major medical complications continuing to present a health risk:

Major psychiatric complication continuing to present a health risk or severe neurological and/or psychological symptoms have not been satisfactorily reduced:

F. Current DSM Diagnoses

G. Number of withdrawal management days requested:

Dates from*: to*:

H. Requesting Provider Information

Requesting Provider Printed Name*:

Provider License No.:	Requesting Provider NPI*:
QCC Signature *(stamped signatures not accepted)*	Date

* Essential/Critical field