Residential Substance Use Disorder Treatment 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

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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 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*:
Taxonomy*:		Benefit Code*:

B. Factors for Admission (complete all sections except section D)

Client is medically stable and not in acute withdrawal	☐ Yes ☐ No
Client is bed-confined or has medical complications that would hamper participation in the residential service	☐ Yes ☐ No
Client manifests severe social isolation or withdrawal from social contacts	☐ Yes ☐ No
Client lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed	☐ Yes ☐ No
Client is coherent, rational, and oriented for treatment	☐ Yes ☐ No
Client can comprehend and understand the materials presented	☐ Yes ☐ No
Client can participate in rehabilitation/treatment process	☐ Yes ☐ No
Client will be able to improve and/or internalize his/her motivation toward recovery	☐ Yes ☐ No
Client's family/significant others are opposed to the client's treatment efforts and are unwilling to participate in the treatment process	☐ Yes ☐ No
Family members/significant others living with the client manifest current chemical dependance disorders, and are likely to undermine treatment	☐ Yes ☐ No
Interventions, treatment goals, and/or contracts are in place to help the client deal with or confront the barriers to treatment:	☐ Yes ☐ No
Client's chemical substance use is excessive, and the client has attempted to reduce or control it, but has been unable to do so	☐ Yes ☐ No
Logistic impairments preclude participation in an outpatient treatment service	☐ Yes ☐ No
Client's daily activities revolve around obtaining, using, and/or recuperating from the effects of chemical substances and the client requires a secured environment to control the client's access to chemical substances	☐ Yes ☐ No

* Essential/Critical field

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C. Adolescent Clients Only	
Adolescent is assessed as manifesting physical maturation at least in middle adolescent range	☐ Yes ☐ No
History of the adolescent reflects cognitive development of at least 11 years of age	☐ Yes ☐ No
History of inability to function within the expected age norms despite normal cognitive and physical maturation	☐ Yes ☐ No
Recent history of moderate/severe conduct disorder/impulsive disregard for social norms and rights of others	☐ Yes ☐ No
Difficulty in meeting developmental expectations in a major area of functioning to an extent which interferes with the capacity to remain behaviorally stable	☐ Yes ☐ No
D. Continued Stay (complete only sections A, C, D, E, F, and G if additional treatment days are required)	
Client recognizes/identifies with the severity of the alcohol/drug problem, but demonstrates minimal insight into defeating use of alcohol/drugs and the client is progressing in treatment	☐ Yes ☐ No
Client identifies severity of alcohol/drug problem and manifests insight into relationship with mood-altering chemicals, yet does not demonstrate behaviors indicating problem solving skills necessary to cope with the problem	☐ Yes ☐ No
Client would predictably relapse if moved to a lesser level of care	☐ Yes ☐ No
Documentation in the medical record indicates an intervening medical or psychiatric event which was serious enough to interrupt rehabilitation/treatment, but the client is again progressing in treatment	☐ Yes ☐ No
Documentation in the medical record indicates that the client is being held pending an immediate transfer to a psychiatric, acute medical service, or inpatient withdrawal management service	☐ Yes ☐ No

E. Current DSM Diagnoses

F. Number of Residential Days Requested
Dates from*: to*:

G. Requesting Provider Information	
Requesting Provider Printed Name*:	
Requesting Provider License Number:	Requesting Provider NPI*:
QCC Signature *(stamped signatures not accepted)*	Date

* Essential/Critical field