Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies

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 **512-514-4209**.

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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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.*

Section A: Client and Provider Information (May be completed by provider)			
Client Information			
Client Name*:	Medicaid Number*:	Date of Birth*:	
Physician or Allowed Practitioner Information			
Name*:	Telephone:	Fax:	
License Number:	NPI*:		
Rendering Provider Information			
Name*:	Telephone:	Fax:	
Street Address*:			
City:	State:	ZIP + 4*:	
Tax ID*:	NPI*:	Taxonomy*:	Benefit Code*:
I certify that the services being supplied under this order are consistent with the physician or allowed practitioner's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.			
Rendering Provider Representative's Printed Name:			
Rendering Provider Representative's Signature:		Date Signed:	

Section B: Oxygen Therapy Request (Must be completed by physician or allowed practitioner)					
Type of request: ☐ Initial Request ☐ Renewal Request					
HCPCS Code*	Description of DME Requested	Qty.*	Price	Diagnosis	Brief Diagnosis Description
Note: The "Duration of need for DME" and "Date client last seen by physician or allowed practitioner" below *must* be filled in.					
Duration of need for DME: _____ month(s)	Date client last seen by physician or allowed practitioner:				
Documentation of Medical Necessity					
Date of testing:	Arterial pO_2 (mm HG):	Oxygen Saturation:			
Lowest Oxygen Saturation at rest or with exercise (percent):	or Arterial pO_2 (mm Hg):				
Lowest Oxygen Saturation during sleep (percent):	or Arterial pO_2 (mm Hg):				

* Essential/Critical field

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For pO_2 of 56-59 mm Hg or oxygen saturation 89% or higher (for initial requests only):				
☐ Dependent edema	☐ Cor pulmonale	☐ Erythrocythemia (include hematocrit):		
For cluster headaches, enter the date of neurological examination (for initial requests only):				
Documentation of failed medication therapy (for initial requests only):				
Flow rate (l/min.):		Hours of treatment per day (estimated):		
Is oxygen therapy required for use within the home?			☐ Yes	☐ No
Is oxygen therapy required for traveling when leaving the home?			☐ Yes	☐ No
Client is compliant with oxygen usage as ordered in initial request (for renewal requests only):			☐ Yes	☐ No
Physician or Allowed Practitioner Signature				
☐ **Request is for supplies only. I certify that the client owns his or her own oxygen therapy device.**				
Physician or Allowed Practitioner's Signature:			Date Signed:	

* Essential/Critical field