Cook Children's Health Plan

Durable Medical Equipment (DME) Prior Authorization Request Form

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

General Instructions: The form may be submitted without the Prescribing Provider's signature and date; however, one of the following must be submitted with the request: a signed and dated prescription, a dated written order, or a dated documented verbal order.

Note: If any portion of this form is incomplete, it may cause the prior authorization request to pend for additional information.

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STAR/CHIP Phone: 888-243-3312 STAR/CHIP Fax: 844-643-8402 or 682-885-8402			STAR Kids Phone: 888-243-3312 STAR Kids Fax: 844-843-0005 or 682-303-0005		
Member Name:	Phone:		□ Male □ Female		
Member ID Number:			Date of Birth:		
Medical Diagnoses:					
Place of Service Requested (check one): □ Home □ Office □ Inpatient □ Outpatient □ Other (specify)					
Severity of Request: □ Routine □ Urgent					
Requested Service Code & Modifiers (one line per code)	Date of Service From	Date of Service Through	Service Code Description	Total Units	Cost (MSRP when indicated)
Specialist	Printed Name		Signature	Date	
Qualified Rehab Professional:					
Prescribing Provider:					
Prescribing Provider NPI and License No.:					
Date Member Last Seen by Prescribing Provider:					
Name of Individual Completing Form:			Phone:		
Special Notes:					
Servicing Provider Information					
Name:			Phone:		
Address:			Fax:		
NPI:	Tax ID:		Taxonomy:	Benefit Code:	

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Providers should submit all prior authorization requests via the Secure Provider Portal. If you must submit by fax or email Providers may use this form or the current Texas Medicaid Standardized Prior Authorization Form. This form may be used for Members of all ages, for initial authorization requests, and for all subsequent recertification requests.

Providers must submit recertification requests no earlier than 60 days before the current authorization period expires. Providers must submit required documentation demonstrating medical necessity, and obtain necessary orders and signatures, as outlined in the Texas Medicaid Provider Procedures Manual (TMPPM) for the requested service.

Directions for completing the Durable Medical Equipment Prior Authorization Request Form:

Field	Explanation
Member Name	Enter the Member's name including middle name or initial if known.
Member ID Number	Enter Member's Medicaid 9-digit identification number.
Date of Birth	Enter the Member's date of birth.
Medical Diagnoses	Enter Member's ICD-10 Code(s) and diagnoses for the medical conditions that require authorization of services.
Place of Service Requested	Enter the place of service requested as appropriate to Provider type.
Severity of Request	Please indicate if the request is routine or urgent. Please note, if the Member is discharging from an inpatient hospital, urgent may be selected to prevent a delay in Member discharge. Requests marked as urgent that are not, will be processed as a routine request.
Dates of Service From & Through	On the line for each service code requested enter the requested service dates: "The From" date should be the date requested services are to be initiated. "The Through" date should be the last date the requested services are to be requested. Enter applicable modifier(s) for the requested service code.
Total Number of Units Requested	Calculate and enter the total number units requested for the authorization period that is being requested. Indicate unit with each requested service code.
Service Code Description	Enter the description of the service code(s) being requested.
Cost	Enter all charges that will be billed to Cook Children's Health Plan.
Prescribing Provider, Printed Name, Signature, Date	If the Prescribing Provider is signing the form, the Provider must print, sign and date the form. The form may be submitted without the Prescribing Provider's signature and date, but the form must be accompanied by a signed and dated written order, prescription, or documented verbal order and include frequency and duration of services. All verbal orders must be co-signed by practitioners that include verbal orders within their scope of practice.
Prescribing Provider NPI and License No.	Enter the Prescribing Provider's NPI and License Number.
Date Member Last Seen by Prescribing Provider	Enter the date the Member was last seen by the Prescribing Provider.
Servicing Provider Information	This section is for the Provider or agency who is billing for the requested services.
Name, Phone, Address, Fax, NPI and Tax ID	Enter the contact information for the Provider or agency. The phone and fax number will be used for authorization approvals or to request additional information. The address should be the same as the one associated with the Provider's NPI.
Benefit Code	Enter taxonomy code and benefit code.

SUBMIT REQUEST