Cook Children's Health Plan

Physical, Occupational, or Speech Therapy 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:
Condition: □ Acute (up to 60-day authorization) □ Chronic (up to 180-day authorization)			
Treatment Diagnoses:		Medical Diagnoses:	
Place of Service Requested (check one): □ Home □ Office □ Inpatient □ Outpatient □ Other (specify)			
Date of Last Therapy Evaluation or Re-Evaluation:	PT:	OT:	ST:

Attach a copy of the therapy evaluation/re-evaluation or progress summary (acute) for each therapy discipline requested below. Provide all other required documentation for an authorization as listed in the Texas Medicaid Provider Procedures Manual.

Discipline and Modifier	Dates of Service		Projected Frequency (per week or per month) *	Total Units or Encounters (visits)
	From	Through		
PT (GP)				
OT (GO)				
ST (GN)				

*If projected frequency will be tapered down or variable, indicate frequency plans here. If Member is to be discharged, write "discharged" and date of discharge in this space:

Procedure Codes Requested:

Specialist	Printed Name	Signature	Date
Physical Therapist:			
Occupational Therapist:			
Speech Therapist:			
Prescribing Provider:			

Prescribing Provider NPI and License No.:

Date Member Last Seen by Prescribing Provider:

Name of Individual Completing Form: Phone:

The Provider's signature certifies the Member's medical record includes a completed, signed and date Plan of Care (POC) that contains all elements of the Texas Medicaid POC, including, for Members birth through 20 years of age, a current Texas Health Steps checkup or developmental screening performed within the last 60 calendar days. The form may be submitted without the Prescribing Providers' 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.

Therapy Billing 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 Therapy Prior Authorization Form. This form may be used for Members of all ages, for initial authorization requests, and for all subsequent recertification requests.

Before requesting prior authorization for PT, OT, or ST services, Providers must complete all required documentation, and obtain necessary orders and signatures, as outlined in the Texas Medicaid Provider Procedures Manual (TMPPM). All recertification requests must be received before the current authorized period expires. Providers must submit recertification requests no earlier than 60 days before the current authorization period expires.

Directions for completing the 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.
Condition: □ Acute □ Chronic	All acute therapy services must have the AT modifier on the submitted claim. Therapy services address a Member's acute or chronic need(s). Acute therapy services are a benefit for Members of all ages and are intended improve, adapt, restore, or maintain function that have been lost or impaired due to a recent illness, injury, loss of a body part, congenital anomaly, or due to a developmental delay or chronic medical condition. Therapy services for chronic conditions are a benefit for Members ages 20 years and younger to address behaviors or skills that allow the Member to achieve outcomes relevant to his/her health, safety, or independence in the context of everyday environments. Approvals for therapy service requests are contingent upon meeting Cook Children's Health Plan's therapy guidelines and criteria. Texas Medicaid Provider Procedures Manual, Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook, 5.1.1; 5.1.2; 6.1.1
Treatment Diagnoses	Enter Member's ICD-10 Code(s) or diagnoses for the medical conditions that require therapy services.
Medical Diagnoses	Enter Member's ICD-10 Code(s) or diagnoses for the medical conditions that require therapy services.
Place of Service Requested	Enter the place of service requested as appropriate to Provider type.
Date of Last Therapy Evaluation or Re-evaluation (PT, OT, ST)	Enter the applicable dates for PT, OT, or ST evaluations or re- evaluations. ***Note: A copy of the applicable therapy evaluation or re- evaluation, for each therapy discipline requested, must be submitted with the request form.***
Dates of Service: From & Through	On the line for each therapy discipline (PT, OT or ST) requested enter the requested service dates: "The From" date should be the date therapy treatment services are to be initiated. "The Through" date should be the last date the therapy services are to be requested. ***Note: For chronic conditions, under CCP only, the authorization period is 180 calendar days. For acute conditions, the authorization period is 60 calendar days.***

Projected Frequency (per week or per month)	Enter the number of therapy sessions planned for the Member each week or per month. Monthly frequencies are limited to 1, 2, or 3 times per month. Requested periods must always be noted in weeks or by the month. Refer to the Cook Children's Health Plan chronic therapy guidelines or TMPPM for information about additional documentation required when requesting a frequency of 3 times a week or more. If the projected frequency will be tapered down or variable, indicate the frequency plans in the space provided.
Total Number of Units or Encounters Requested	Calculate and enter the total number of 15-minute units requested for time-based procedure codes. Calculate and enter the total number of encounters for encounter based procedure codes. Indicate unit or encounter with each request. When requesting a combination of encounter and unit-based therapy treatment codes, please describe the combination in the field designated for tapered down frequency requests.
Procedure Codes Requested	Enter all relevant treatment procedure codes the Provider is requesting.
Specialist, Printed Name, Signature, Date	Each therapy Provider (PT, OT, or ST) who will be delivering services to the Member is required to print, sign, and date his/her name.
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. This date will be used for reference by reviewers to determine if the acute condition or acute exacerbation of a condition is within 90 calendar days of the requested therapy services.
Therapy Billing Provider Information	This section is for the Provider or agency who is billing for the therapy 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 for authorization approvals or to request additional information. The address should be the same as the one associated with the Provider's NPI.
Taxonomy and Benefit Code	Enter taxonomy code and benefit code.

SUBMIT REQUEST