CookChildren's
Health Plan

Comprehensive Care Program
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: 682-303-0005 or 844-843-0005

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.*

Request for:	□ ABA	□ DME	□ Supplies	□ Private Duty Nursing	□ PPECC	□ Inpatient Rehabilitation	□ Other

A: Client Information

Client Name (Last, First, M.I.)*:	
Medicaid Number*:	Date of Birth*:

B: Rendering Provider/Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information

Name*:	Telephone:	Fax:	
Street Address*:			
City:	State:	ZIP + 4*:	
Tax ID*:	NPI*:	Taxonomy*:	Benefit Code*:
QRP Name:	QRP Tax ID:	QRP NPI:	
QRP Taxonomy:	QRP Benefit Code:		
QRP Street Address:			
City:	State:	ZIP + 4:	

C: Type of Request

□ ABA Evaluation	Requested Start Date*:	Requested End Date*:
□ ABA Re-evaluation	Requested Start Date*:	Requested End Date*:
□ ABA Treatment	Requested Start Date*:	Requested End Date*:
□ Initial / New Client	Requested Start Date*:	Requested End Date*:
□ Recertification	Requested Start Date*:	Requested End Date*:
□ Revision**	Revised Start Date*:	End Date*: (Cannot extend beyond current authorization period.)

** Reason for Revision:

D: Diagnosis and Medical Necessity of Requested Services (Initial and Recertification)

* Essential/Critical field

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E: Dates of Service and HCPCS Code			
Dates of Service:	From*:	To*:	
HCPCS Code* / Modifier	Brief Description of Requested Services	Quantity* / Frequency*	Retail Price
Note: *HCPCS codes and descriptions must be provided.*			

F: Primary Practitioner's Certifications (To be completed by the requesting practitioner)

By requesting ABA evaluation or treatment, I certify:
- The client is under 21 years of age AND
- The client has a diagnosis of Autism Spectrum Disorder AND
- ABA services are or may be clinically indicated

By requesting the identified DME and/or medical supplies, I certify:
- The client is under 21 years of age AND
- The prescribed items are appropriate and can safely be used by the client when used as prescribed

By requesting Private Duty Nursing, I certify:
- The client is under 21 years of age AND
- The client's medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

By requesting PPECC services, I certify:
- The client is under 21 years of age AND
- The client's medical condition is sufficiently stable to permit safe delivery of PPECC services as described in the PPECC plan of care.

Note: *Signatures from chiropractors and doctors of philosophy (PhDs) will not be accepted. Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP) and Physician Assistant (PA) providers may sign on behalf of the physician for Applied Behavior Analysis (ABA) services, Private Duty Nursing, Physical, Occupational, and Speech Therapy Services when the physician delegates this authority. Signature stamps and date stamps are not acceptable.*

Signature of requesting physician:	Date:
Printed or typed name of physician*:	
NPI*:	License No.:

* Essential/Critical field