CookChildren's Health Plan

Durable Medical Equipment/Supplies (DME)
Prior Authorization Request Form

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

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.

CookChildren's Health Plan

Durable Medical Equipment/Supplies (DME)
Prior Authorization Request Form

Star/CHIP Phone: 682-885-2247 or 1-800-862-2247 **Star/CHIP Fax: 682-885-8402 or 1-844-643-8420**	**Star Kids Phone: 682-885-2245 or 1-888-243-3312** **Star Kids Fax: 682-303-0005 or 1-844-843-0004**

Member Name:	**Phone:**	☐**Male** ☐**Female**
Member ID Number:		**Date of Birth:**
Medical Diagnoses with ICD-10 Code:		

Place of Service Requested (please check *one* of the following):

☐**Home**	☐**Other, specify:**	☐**Routine** ☐**Urgent**

Requested Service Code & Modifiers *(Please use one line per code)*	**Dates of Service**		**Service Code Description**	**Total Units**	**Cost** *(MSRP when indicated)*
	From	**Through**			

Specialist	**Printed Name**	**Signature**	**Date**
Qualified Rehab Professional (when applicable)			
Prescribing Provider			

Prescribing Provider NPI and License No.:

Date client last seen by prescribing provider:

Name of Individual Completing Form: **Phone Number of Individual Completing Form:**

Special Notes:

Servicing Provider Information

Name:			**Telephone:**
Address:			**Fax:**
TPI:	**NPI:**	**Taxonomy:**	**Benefit Code:**

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.

Durable Medical Equipment/Supplies (DME)
Prior Authorization Request Form

General Instructions:

Effective August 1, 2019, all providers requesting Durable Medical Equipment (DME) and Medical Supply Prior Authorization services for Cook Children's Health Plan members may use the CCHP Durable Medical Equipment/Supplies (DME) Prior Authorization Form or current Standardized Prior Authorization form. This form may be used for members of all ages, for initial authorization requests, and for all subsequent recertification requests in lieu of the Title XIX form. Prior Authorization requests may be submitted by fax or via CCHP Secure Provider Portal

Providers must submit required documentation demonstrating medical necessity, and obtain necessary orders and signatures, as outlined in the Texas Medicaid Providers Procedures Manual (TMPPM) for the requested service. Providers must submit recertification requests no earlier than 30 days before the current authorization period expires.

Directions for completing the Durable Medical Equipment/Supplies (DME) PriorAuthorization 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. Request marked as urgent that are not will be processed by CCHP as a routine request.
Service Code and Modifier 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 CCHP
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 client last seen by prescribing provider	Enter the date the client 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, Telephone, Address, Fax, TPI, NPI	Enter the contact information for the provider or agency. The telephone and fax number will be used by CCHP for authorization approvals or to request additional information. The address should be the same as the one associated with the provider's NPI or TPI.
Taxonomy and Benefit Code	Providers need to enter taxonomy code and benefit code information if they do not enter their TPI on the form and they have multiple physical locations or program enrollments under the same NPI.

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.