Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form

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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See instructions for completing the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form. This order form cannot be accepted beyond 90 days from the date of the prescribing provider's signature.

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: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): ☐ Requesting Physician or Allowed Practitioner ☐ Rendering Provider

Client Information

Client Name*:	Medicaid Number*:	Date of Birth*:

Rendering Provider Information

Name*:	Telephone:	Fax:
Street Address*:		
City:	State:	ZIP + 4*:

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

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's Signature:	Date:
Rendering Provider Name (typed or printed):	

Requesting Physician or Allowed Practitioner Information

Name*:	Telephone:	Fax:

Item Number	HCPCS Code*	Description of DME/Medical Supplies	Qty.*	Price	Prior Authorization Required?	Beyond Quantity Limit?[1]	Custom Item?[1]
1					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
2					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
3					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
4					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

* Essential/Critical field

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Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician or allowed practitioner.

Item Number[2] (From Section A)	Diagnosis Code	Brief Diagnosis Description	Complete justification for determination of medical necessity for requested item(s) [2] (Refer to Section A, footnote 1)

2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification. Enter all Item numbers from the table in Section A that pertain to each diagnosis. A range of item numbers may be entered.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status:

Note: The "Date last seen" and "Duration of need" items must be filled in.	Date last seen by physician or allowed practitioner:
Duration of need for DME: _____ month (s)	Duration of need for supplies: _____ month (s)

By signing this form, I hereby attest that the information in Section "A", with the exception of the rendering provider's signature, was complete at the time of my signature and is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and Attestation of Requesting Physician or Allowed Practitioner:	Date:
Signature stamps and date stamps are not acceptable	
NPI*:	License Number:

* Essential/Critical field