# Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization 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. 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. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To submit by fax, send to **512-514-4212**.

**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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**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.*

| **Comprehensive Care Program (CCP)**<br>**Fax: 1-512-514-4212** | **Special Medical Prior Authorization (SMPA)**<br>**Fax: 1-512-514-4213** | **Home Health (HH) Services**<br>**Fax: 1-512-514-4209** |
|---|---|---|

Client Name*:

Medicaid 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 (please check *one* of the following):**

☐ Office | ☐ Outpatient | ☐ Home | ☐ 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 Number of Units or Encounters Requested |
|---|---|---|---|---|
| | From* | Through* | | |
| **PT (GP)** | | | | |
| **OT (GO)** | | | | |
| **ST (GN)** | | | | |

** If projected frequency will be tapered down or variable, indicate frequency plans here. If client 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 | | | |
| Requesting Provider* | | | |

Requesting Provider NPI and License No.*:

Date client last seen by requesting provider:

**The provider's signature certifies the client's medical record includes a completed, signed and dated Plan of Care (POC) that contains all elements of the Texas Medicaid POC, including, for clients 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 requesting 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.**

**Rendering Therapy Billing Provider Information**

Name*: | Telephone: | Fax:

Street address*: | City: | State: | ZIP + 4*:

Tax ID*: | NPI*: | Taxonomy*: | Benefit Code*:

* Essential/Critical field