Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-emergency Ambulance Prior Authorization Request

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 **512-514-4205**.

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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Submit completed form by fax to **512-514-4205.**

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.*

Requesting Provider Information

Requesting Provider Name*:		
Requesting Provider NPI*:		Date Request Submitted:
Contact Name:	Telephone:	Fax:

Rendering Provider Information

Rendering Ambulance Provider*:		Ambulance NPI*:
Tax ID*:	Benefit Code*:	Taxonomy*:
Street Address*:		
City:	State:	ZIP + 4*:

Client Information

Client Name (*Last, First, MI*)*:	
Client Medicaid/CSHCN Number*:	Date of Birth*:
Is the client morbidly obese? ☐ No ☐ Yes	Client Weight (*pounds*):

Are all other means of transport contraindicated? ☐ No ☐ Yes

If "no," this client does not qualify for non-emergency ambulance transport.

If "yes," please complete the remainder of the form.

Reason for Transport:

Origin:	Destination:

Method of Transport: ☐ Ground ☐ Fixed Wing ☐ Helicopter ☐ Specialized

Request Type

☐ One-Time/Non-Repeating	Date*:

☐ Recurring Number of days requested*: _____ days (2-60 days) Begin Date*: _____

Note: *For an exception to the one-time or recurring request type, refer to the Non-emergency Ambulance Exception request in the applicable provider manual, and submit with the Non-emergency Ambulance Exception Request Form.*

Reason for Recurring Transport (2-60 day request type):

☐ Dialysis ☐ Radiation Therapy ☐ Physical Therapy ☐ Hyperbaric Therapy ☐ Other (explain below):

Estimated number of visits during these authorization dates:

Explain why transport is more cost effective than servicing the client at residence:

* Essential/Critical field

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Requested Services

HCPCS Procedure Code*:	Brief Description of Services:

Condition Affecting Transport (Check Each Applicable Condition)

Physical or mental condition affecting transport:

Client requires monitoring by trained staff because:

☐ Oxygen (portable O_2 does not apply) ☐ Airway ☐ Suction ☐ Hyperbaric Therapy

☐ Comatose ☐ Cardiac ☐ Life Support ☐ Behavioral

How does the client transfer? ☐ Assisted ☐ Unassisted

Is the client bed-confined (i.e., unable to sit in a chair, stand and ambulate)? ☐ Yes ☐ No

If "No," please indicate the following:

Does the client use an assistive walking device? ☐ Yes ☐ No

Is the client able to stand? ☐ Yes ☐ No

The client is able to sit in which of the following for the duration of the transport:

☐ Chair ☐ Wheelchair ☐ Geri-Chair ☐ Cardiac Chair If able to sit up, for how long: _____

Does the client pose immediate danger to self or others? ☐ Yes ☐ No If "Yes," describe circumstances below:

In addition to ambulance standards, does the client require additional physical restraint? ☐ Yes ☐ No

If "Yes," select the type: ☐ Wrist ☐ Vest ☐ Straps ☐ Other (describe below):

☐ Extra attendant must be certified by DSHS to provide emergency medical services (explain below):

* Essential/Critical field

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Condition Affecting Transport (Check Each Applicable Condition)

☐ Continuous IV therapy or enteral/parenteral feedings**

☐ Advanced decubitus ulcers**

☐ Chemical sedation**

☐ Contractures limiting mobility**

☐ Decreased level of consciousness**

☐ Must remain immobile (i.e., fracture)**

☐ Isolation precautions (VRE, MRSA, etc.)**

☐ Decreased sitting tolerance time or balance**

☐ Wound precautions**

☐ Active seizures**

** Provide additional detail (i.e., type of seizure or IV therapy, body part affected, supports needed, or time period for the condition) or provide detail of the client's other conditions requiring transport by ambulance:

Certification

I certify the information supplied in this document is true, accurate, complete, and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law which can result in fines or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.

Requesting Provider Printed Name*:	
Title: ☐ Physician ☐ Advanced Practice RN ☐ Physician's Assistant ☐ RN ☐ Discharge Planner	
Requesting Provider NPI*:	
Requesting Provider Signature:	Date Signed:

* Essential/Critical field

Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-emergency Ambulance Prior Authorization Request

Provider Instructions for Non-emergency Ambulance Prior Authorization Request Form

This form must be completed by the provider requesting non-emergency ambulance transportation. [Medicaid Reference: Chapter 32.024(t) Texas Human Resources Code]

All non-emergency ambulance transportation must be medically necessary. Texas Medicaid, CSHCN Services Program, and Medicare have similar requirements for this service to qualify for reimbursement. This form is intended to accommodate all of the programs' requirements. For additional information and changes to this policy and process refer to the respective program information: *Texas Medicaid's Provider Procedures Manual*, *CSHCN Services Program Provider Manual*, banner messages, and to Medicare's manuals, newsletters and other publications.

1. **Requesting Provider Information**—Enter the name of the entity requesting authorization. (i.e., hospital, nursing facility, dialysis facility, physician).
2. **Request Date**—Enter the date the form is submitted.
3. **Requesting Provider Identifiers**—Enter the following information for the requesting provider (facility or physician):
   - Enter the requesting provider's name.
   - Enter the National Provider Identifier (NPI) number. An NPI is a ten-digit number issued by the National Plan and Provider Enumeration System (NPPES).
4. **Ambulance Provider Identifiers**— Enter the following information for the rendering ambulance provider.
   - Enter the rendering ambulance provider's name.
   - Enter the rendering ambulance provider's NPI.
   - Enter the rendering ambulance provider's Tax ID.
   - Enter the rendering ambulance provider's Benefit Code.
   - Enter the requested ambulance provider's primary national taxonomy code. This is a ten-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com.
   - Enter the requested ambulance provider's address, including ZIP + 4 Code.
5. **Client Information**— This section must be filled out to indicate the client's name in the proper order (last, first, middle initial). Enter the client's date of birth and client number. The client's weight must be listed in pounds. Check yes if the physician has documented that the client is morbidly obese. If a client is currently an inpatient at a hospital facility, any ambulance transports are the responsibility of the hospital. One time ambulance transports related to a hospital discharge may be considered for prior authorization.
6. **Requested Services**—Enter the requested Healthcare Common Procedure Coding System (HCPCS) procedure code and a brief description of the requested services. The applicable codes are listed below:

Procedure Codes			
A0382	A0398	A0422	A0424
A0425	A0426	A0428	A0430

* Essential/Critical field

Procedure Codes			
A0431	A0433	A0434	A0435
A0436	A0999		

7. **Client's Current Condition**—This section must be filled out to indicate the client's current condition and not to list all historical diagnoses. Do not submit a list of the client's diagnoses unless the diagnoses are relevant to transport (i.e., if client has a diagnosis of hip fracture, the date the fracture was sustained must be included in documentation). It must be clear to TMHP when reviewing the request form, exactly why the client requires transport by ambulance and cannot be safely transported by any other means.
8. **Details for Checked Boxes**—For questions with check boxes at least one box must be checked. When sections require a detailed explanation, the information must be provided (i.e., if contractures is checked, please give the location and degree of contracture[s]).
9. **Isolation Precautions**—Vancomycin-Resistant Enterococci (VRE) and Methicillin-Resistant Staphylococcus Aureus (MRSA) are just two examples of isolation precautions. Please indicate in the notes exactly what type of precaution is indicated.
10. **Request Type**—Check the box for the request type. A one-time, non-repeating request is for a one day period. A recurring request is for a period of 2-60 days. The provider must indicate the number of days being requested along with the begin date.
11. **Name of Person Signing the Request**—All request forms require a signature, date, and title of the person signing the form. A one-time request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the client's condition. A recurring request must be signed and dated by a physician, PA, NP, or CNS. The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.
12. **Signing Provider Identifier**—This field is for the NPI number of the requesting facility or provider signing the form.

* Essential/Critical field