Prescribed Pediatric Extended Care Center (PPECC) Plan of Care

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 **512-514-4212**.

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*.

Section A: Client Information		
Client's name*:	Date of birth*:	
Date last seen by ordering physician:	Medicaid number*:	
Section B: PPECC Provider Information		
Name*:	Fax:	Telephone:
Hours of operation: Open:_____a.m. Close:_____p.m. ☐ Central Time ☐ Mountain Time		
Street address*:		
City:	State:	ZIP + 4*:
PPECC provider license number:	Benefit Code*:	
Tax ID:	NPI*:	Taxonomy*:
Date of PPECC nursing assessment:		
Registered Nurse's name:	Telephone:	
Title / credentials of RN:		
Section C: Private Duty Nursing (PDN) Provider Information (If known, PPECC to complete this section if the client receives PDN services)		
Name:	Fax:	Telephone:
Street address:		
City:	State:	ZIP + 4:
Tax ID:	NPI:	
Section D: Requesting Physician Information		
Name*:	NPI*:	Telephone:
Section E: Plan of Care Information		
Status (check one):	☐ Initial / New client	☐ Recertification ☐ Revision
Requested start date*:	Requested end date*:	
Services client receives from other agencies, and if applicable, from the client's school:		
Client schedule:		
Diagnoses, including known allergies:		
Functional limitations / Permitted activities:		
Nutritional requirements (type, method of administration and frequency):		
Mental status:		
Prognosis:	Rehabilitation potential:	

*Essential/Critical field

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Section E: Plan of Care Information (cont.)	
Safety precautions:	
Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if OT/PT requested, permitted activities, etc.):	
Client stable to receive PPECC transportation services? ☐ Yes ☐ No If yes, who must accompany the client on the PPECC transport vehicle? ☐ RN/LVN ☐ Direct care staff	
Client and/or responsible adult training needs:	
Responsible adult:	Telephone:
Emergency contact:	Telephone:
Wound description and ordered care:	
Nursing services requested:	
Therapies (OT, PT, ST) to be provided in the PPECC:	
Therapies (OT, PT, ST) provided outside of PPECC:	
Equipment or supplies required. Will the equipment required be brought from home, or provided at the PPECC?	

*Essential/Critical field

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Section E: Plan of Care Information (cont.)

Other treatments or prescribed services, including the amount, frequency and duration that are provided in the PPECC, includingfunctional development and psychosocial services:

Prescribed Medication	Route	Dose	Frequency		Prescribed Medication	Route	Dose	Frequency

Signed contingency plan in place? ☐ Yes ☐ No

Section F: Required Signatures

The RN signing below must be the same RN named in Section B, above. The physician's signature on this form is required to be from the same physician who signed the CCP Prior Authorization Request Form. This signature serves as the physician order for PPECC services.

RN signature:	Date signed:
Requesting physician signature:	Date signed:

Conflict of Interest Statement

PPECC Prescriber Conflict of Interest Statement:

By signing this form, I certify that I am in compliance with federal or state rule or law prohibiting self-referral or kick-backs (check the appropriate box below):

☐ I do have a financial interest that complies with federal or state rule or law prohibiting self-referral or kick-backs.

☐ I do *not* have a financial interest, and comply with federal or state rule or law prohibiting self-referral or kick-backs.

*Essential/Critical field