THSteps-CCP Prior Authorization Request Form

If any portion of this form is incomplete, it will be returned.

Request for:	☐ **DME**	☐ **Supplies**	☐ **Private Duty Nursing**	☐ **Inpatient Rehabilitation**	☐ **Other**

Client Information

Client Name (Last, First, MI):	
Medicaid Number (PCN):	Date of Birth: / /

Supplier/Vendor Information

Supplier Name:	Telephone:	Fax Number:	
Supplier Address:			
TPI:	NPI:	Taxonomy:	Benefit Code:

Diagnosis and Medical Necessity of Requested Services

Dates of Service	From: / /	To: / /

HCPCS Code	Brief Description of requested Services	Retail Price

Note: *HCPCS codes and descriptions must be provided.*

Primary Practitioner's Certifications—To be completed by the primary practitioner

By prescribing the identified DME and/or medical supplies, I certify to the following:

☐ The client is under 21 years of age AND

☐ The prescribed items are appropriate and can safely be used by the client when used as prescribed

For Private Duty Nursing, I certify:

☐ The client's medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

Signature of prescribing physician:		Date:
Printed or typed name of physician:		
TPI:	NPI:	License Number:

Contact Information for Completed Forms

Fax Number:	**1-512-514-4212**
Mailing Address:	**CCP** **PO Box 200735** **Austin, TX 78720-0735**

For TMHP Use Only

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