Driscoll Health Plan

CCP Prior Authorization Request Form Instruction

General Instructions

This form must be completed and signed as outlined in the instructions below before the prior authorization is submitted to Driscoll Health Plan (DHP).

Either the requesting Medicaid provider or the requesting physician may initiate the form. The completed form with the original dated signature must be retained by the requesting physician in the client's medical record. A copy of the signed and dated form must be maintained by the requesting provider in the client's medical record. The form is subject to retrospective review.

The Medicaid provider or requesting physician may complete the following sections:

- Request for Services checkboxes
- Section A: Client Information
- Section B: Provider/Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information
- Section C: Type of Request
- Section E: Dates of Service and Healthcare Common Procedure Coding System (HCPCS) Procedure Codes

The requesting physician must complete the following sections:

- Section D: Diagnosis and Medical Necessity of Requested Services
- Section F: Primary Practitioner's Certifications

Fields marked with an asterisk below indicate an essential element/critical field. If these fields are not completed, your prior authorization request will be returned.

Request of Services

Check the appropriate type of service being requested. Only one box may be selected.

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

Section A: Client Information

Enter the client's name, Medicaid number, and date of birth as indicated on the Texas Medicaid eligibility card or form.

Client Name (Last, First, M.I.) *: Jane Doe	
Medicaid Number*: 987654321	Date of Birth*: 01 / 01 / 2011

Section B: Rendering Provider/Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information

Enter the names, telephone, fax number, address, Tax ID, and NPI of the Requesting Provider and the Referred to Medicaid Provider who will be providing the requested service or benefit.

If requesting a wheeled mobility system, enter the QRP's name, Tax ID, and NPI.

Requesting Provider Name*: ABC DME Company	Telephone: 123-555-1234	Fax: 123-555-1234
Street Address: 123 Street Drive		
City: Somewhere	State: TX	ZIP + 4: 12345-1234

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Tax ID: 123456701	NPI*: 1234567891	Taxonomy: 123XX4567X	Benefit Code: XXX
Referred to Provider Name*: B. Provider		Tax ID*: 123456701	NPI*: 1234567891
Taxonomy: 123XX4567X		Benefit Code: XXX	
Street Address: 456 Street Blvd.			
City: Somewhere		State: TX	ZIP + 4: 12345-1234

Section C: Type of Request

Check the appropriate box for the type of authorization being requested. If the request is for a revision to an existing authorization, the requested end date cannot extend beyond the original authorization's end date. Provide an explanation for the revision in the space provided.

- For ABA services, check the appropriate ABA box(es) or Revision as applicable.
- For all other services, check one of the remaining box(es) or Revision as applicable.

ABA Evaluation	Requested Start Date*: 01 / 01 / 2021	Requested End Date*: 01 / 31 / 2021
ABA Re-evaluation	Requested Start Date*:	Requested End Date*: 01 / 31 / 2021
ABA Treatment	Requested Start Date*:	Requested End Date*:
Initial / New Client	Requested Start Date*:	Requested End Date*:
Recertification	Requested Start Date*:	Requested End Date*:
Revision**	Revised Start Date*:	End Date*: (Cannot extend beyond current authorization period.)
** Reason for Revision:		

Section D: Diagnosis and Medical Necessity of Requested Services

Section D: Initial and Recertification.

The requesting physician must include a valid diagnosis code (the code used below is for example only) with a brief description and complete justification for determination of medical necessity for the requested items or services. If applicable, the requesting physician should include the client's height/weight, wound/stage/ dimensions, and functional/mobility, or any other documentation to support the medical necessity.

Diagnosis code I1XXX - The patient has malignant hypertension and requires 24-hour monitoring of their blood pressure to confirm diagnosis and regulate medication. The client has been hospitalized twice in the last 6 months (11/02/16 and 12/15/16) for hypertension. The client's symptoms are (list symptoms), and the initial evaluation showed (add description). The patient needs to monitor and record blood pressure once every hour and cannot tolerate a manual device (bruises easily).

Section E: Dates of Service and HCPCS Codes

Enter the From*: and To*: dates of service for requested services.

Dates of Service:	From*: 03 / 01 / 2021	To*: 05 / 31 / 2021

HCPCS Code/Modifier, Brief Description of Requested Services, Quantity/Frequency, and Retail Price
Enter the appropriate and most specific HCPCS code (the code used below if for example only), the appropriate modifier (if required), and brief description of the requested item or service.

Enter the appropriate quantity and frequency based on the physician's prescription.

Enter the AWP or MSRP for DME or supplies that have no maximum fee listed in the Texas Medicaid Fee Schedule.

If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

HCPCS Code/Modifier*	Brief Description of Requested Services	Quantity*/Frequency*	Retail Price
A9XXX / U1	Rental of blood pressure monitoring device automatic	1/Month	$40.00
Note: *HCPCS codes and descriptions must be provided.*			

Section F: Primary Practitioner's Certifications

To be completed by the requesting physician.

The requesting physician must sign and date the form and print or type physician name. By signing Section F, the requesting physician certifies the following:

- For ABA evaluation or treatment, the client is under 21 years of age and the client has a diagnosis of Autism Spectrum Disorder and ABA services are or may be clinically indicated.
- For DME and/or medical supplies, the client is under 21 years of age and the DME and/or medical supplies are appropriate and can safely be used by the client when used as prescribed.
- For Private Duty Nursing, the client is under 21 years of age and the client's medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.
- For PPECC Services, the client is under 21 years of age and the client's medical condition is sufficiently stable to permit safe delivery of PPECC services as described in the PPECC plan of care.

The requesting physician's NPI and license number must be documented. Physicians must indicate their professional license number. If the requesting physician is out of state, the physician must provide the license number and state of professional licensure.

Note: *Signatures from chiropractors and doctors of philosophy (PhDs) will not be accepted. Signature stamps and date stamps are not acceptable.*

Signature of requesting physician:	Date:
John Smith Digitally signed by John Smith DN: cn=John Smith, o=docname123, ou, email=johnsmith@docname123.com, c=US Date=2016.12.01 21:41:51 -4'00'	02 / 01 / 2021
Printed or typed name of physician*: John Smith	
NPI*: 1234567891	License No.: TX12345