

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

Submit completed form by fax to: 1-512-514-4205

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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Condition Affecting Transport (Check Each Applicable Condition)	
Physical or mental condition affecting transport:	
Client requires monitoring by trained staff because:	
<input type="checkbox"/> Oxygen (portable O2 does not apply) <input type="checkbox"/> Airway <input type="checkbox"/> Suction <input type="checkbox"/> Hyperbaric Therapy <input type="checkbox"/> Comatose <input type="checkbox"/> Cardiac <input type="checkbox"/> Life Support <input type="checkbox"/> Behavioral	
How does the client transfer? <input type="checkbox"/> Assisted <input type="checkbox"/> Unassisted	
Is the client bed-confined (i.e., unable to sit in a chair, stand and ambulate)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "No," please indicate the following:	
Does the client use an assistive walking device? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the client able to stand? <input type="checkbox"/> Yes <input type="checkbox"/> No	
The client is able to sit in which of the following for the duration of the transport:	
<input type="checkbox"/> Chair <input type="checkbox"/> Wheelchair <input type="checkbox"/> Geri-Chair <input type="checkbox"/> Cardiac Chair If able to sit up, for how long: _____	
Does the client pose immediate danger to self or others? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," describe circumstances below:	
In addition to ambulance standards, does the client require additional physical restraint? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes," select the type: <input type="checkbox"/> Wrist <input type="checkbox"/> Vest <input type="checkbox"/> Straps <input type="checkbox"/> Other (<i>describe</i>): _____	
<input type="checkbox"/> Extra Attendant must be certified by DSHS to provide emergency medical services (<i>reason</i>):	
<input type="checkbox"/> Continuous IV therapy or enteral/parenteral feedings* <input type="checkbox"/> Advanced decubitus ulcers* <input type="checkbox"/> Chemical sedation* <input type="checkbox"/> Contractures limiting mobility* <input type="checkbox"/> Decreased level of consciousness* <input type="checkbox"/> Must remain immobile (i.e., fracture, etc.)* <input type="checkbox"/> Isolation precautions (VRE, MRSA, etc.)* <input type="checkbox"/> Decreased sitting tolerance time or balance* <input type="checkbox"/> Wound precautions* <input type="checkbox"/> 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 that the information supplied in this document constitutes true, accurate, and complete information 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.	
Printed Name:	
Title: <input type="checkbox"/> Physician <input type="checkbox"/> Advanced Practice RN <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> RN <input type="checkbox"/> Discharge Planner	
Provider Identifier (Medicaid/CSHCN TPI or NPI):	
Signature:	Date Signed:

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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, and 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 Texas Provider Identifier (TPI) number.
 - Enter the National Provider Identifier (NPI) number. An NPI is a ten-digit number issued by the National Plan and Provider Enumeration System (NPPES).
 - Enter the 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.
4. **Ambulance Provider Identifier**— Enter the TPI or NPI number of the requested ambulance provider.
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 that are 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
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 requiring a detail explanation the information must be provided (i.e., if contractures is checked, please give the location and degree of contracture[s]).

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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, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (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 TPI or NPI number of the requesting facility or provider signing the form