



Texas Children's Health Plan

The best decision a family can make.

Prior Authorization Request Form

Phone 832-828-1004 Fax: 832-825-8760

Pre-certification is a condition of reimbursement. It is not a guarantee of payment. It is the responsibility of each provider to verify the member's eligibility prior to rendering services. Providers should initiate the prior authorization process 3 to 5 business days prior to a scheduled service. **An incomplete pre-certification request form will delay processing of your request.**

Date: _____ Name of person completing form: _____

Office number: _____ Fax number: _____

Member name: _____ DOB: _____ Sex: M or F

Member ID number: _____

Primary care provider: _____ Provider NPI: _____

Requesting provider name: _____ Provider NPI: _____

Pay to affiliate: _____ Provider NPI: _____

Facility: _____ Provider NPI: _____

Diagnosis: _____ ICD-9 Code(s): _____

Service(s)/procedures(s) you are requesting: _____

Date of service: _____ Estimated LOS required: _____
(Number of days requesting)

Medical history (Please attach all documentation relevant to the requested procedure). Required for review.

| HCPCS/CPT 4 code(s): code: | Visits/units: | Medicaid type of service | Place of service |
|-------------------------------|---------------|--------------------------|--|
| 1. _____ | 1. _____ | 1. _____ | <input type="checkbox"/> Inpatient <input type="checkbox"/> Observation |
| 2. _____ | 2. _____ | 2. _____ | <input type="checkbox"/> Outpatient <input type="checkbox"/> Home |
| 3. _____ | 3. _____ | 3. _____ | <input type="checkbox"/> Physician's Office <input type="checkbox"/> Day Surgery |

Other insurance: _____ Other insurance phone number: _____
(Please do not write below this line.)

Approved Denied: _____ Effective date: _____

Authorization number: _____ Effective date: _____