

D.63 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 Name (Last, First, MI) _____ Medicaid Number (PCN) _____ Date of Birth _____

Name of Supplier/Vendor _____ TPI _____ Phone Number _____

Phone Number _____

FAX Number _____

Address of Supplier/Vendor _____

Diagnosis and Medical Necessity of requested services:

Dates of Service From _____ To _____

HCPSC Code Brief Description of requested services Retail Price

Note: HCPSC codes and description must be provided

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

- The client is under age 21 **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 _____

Fax completed form to 1-512-514-4212

For TMHP Use Only

Or mail to:

**CCP
PO Box 200735
Austin, TX 78720-0735**