Forms

B.1 Abortion Certification Statements Form

The signature of the physician must be original script (not stamped or typed). A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes are not acceptable at this time.

"I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client's full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed."

Signature _____

"I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities."

Signature _____

"I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities."

Signature _____

B.2 Affidavit

THE STATE OF TEXAS

COUNTY OF _____

AFFIDAVIT

Before me, the undersigned authority, personally appeared, who being by me duly sworn, deposed as follows:

My name is _____

I am of sound mind, capable of making the affidavit, and personally acquainted with the facts herein stated:

I am the custodian of the records of _____
(Facility Name and Address)

_____

Attached here are _____ pages from the medical record of:
(# of Pages)

_____
(Patient Name)

Hospital Stay period: _____
(Admission and Discharge Date)

These pages of records are kept by said Hospital in the regular course of business and it was in the regular course of hospital business for an employee or representative of said Hospital, with knowledge of the act, event, condition, opinion or diagnosis recorded, to make the record or to transmit information thereof to be included in such record and the record was made at or near the time or reasonably soon thereafter.

The record attached hereto is the **original or an exact duplicate of the original** and **no other** documents exist on the files for the above named person, which pertain to the admission and discharge, noted above.

_____
(Signature)

SWORN TO AND SUBSCRIBED before me on this _____ day of _____. 200_____

_____
(Notary Public in and for the STATE OF TEXAS)

SEAL

_____
(Printed Name)

My commission expires: _____

B.3 Ambulance Fax Cover Sheet

Texas Medicaid & Healthcare Partnership
12357-B RIATA TRACE PKWY, STE 150
Austin, TX 78727

DATE: _____ TIME: _____(AM) (PM)

FROM: _____ TO: AMBULANCE UNIT

PHONE: _____ PHONE: 1-800-540-0694

FAX: _____ FAX: 1-512-514-4205

*For clients who meet the definition of severely disabled: The client's physical condition limits his/her mobility, which requires the client to be bed-confined at all times or life support systems to be monitored.

If Hospital to Hospital or Hospital Discharge, supply:

ORIGIN: _____ DESTINATION: _____

All providers supply the following information:

*The requestor's name and title _____

*The client's full name _____

*The client's Medicaid number _____

*The initial transport date _____

*Full name of the transporting Ambulance Company _____

*Texas Provider Identifier (TPI) of the transporting Ambulance Company _____

*National Provider Identifier (NPI) of the transporting Ambulance Company _____

*Taxonomy Code of the transporting Ambulance Company _____

*The type of Prior Authorization being requested: _____Short Term (1–60 days)

Please supply one or more of the following documentation:

*Admit and discharge records for dates of service

*A history and physical that has been done within 6 months

*The Care Plan with Daily Activity Sheet from the Nursing Home within 6 months

*Home Health Care Plan within 6 months

NUMBER OF PAGES INCLUDING COVER SHEET:_____

Effective Date_07302007/Revised Date_11142007

B.4 Authorization to Release Confidential Information (2 Pages)

PATIENT'S NAME _____

I authorize _____ and/or _____, and/or
(Name of HMO) (Name of BHO)

the following person/agency/group:

_____

Provider/Agency/Group Address City State ZIP

To disclose information and records regarding my treatment, medical and/or behavioral health condition to the following professional person/agency, physician and/or facility;

_____

Provider/Agency/Group Address City State ZIP

Information to be released or exchanged include (check all that apply):

_____ History and physical

_____ Discharge and Summary

_____ Behavioral Health Treatment Records

_____ Laboratory Reports

_____ Physical Health Treatment Records

_____ Medication Records

_____ Information on HIV or communicable disease treatment

_____ Other (specify) _____

The authorized purpose(s) for this release are:

_____ Diagnosis and Treatment

_____ Coordination of Care

_____ Insurance Payment Purposes

_____ Other (specify) _____

I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. I may revoke this authorization. This authorization is valid until I revoke it or sixty (60) days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

This authorization was explained to me as I signed it of my own free will on:

The _____day of _____, 20____.

_____ _____

Signature of Client Signature of Witness

_____

Signature of Parent, Guardian, or Authorized Representative, if required

NOTICE OF CLIENT'S REFUSAL TO RELEASE INFORMATION:

I have reviewed the above release of information form and refuse to authorize release of health and behavioral health information to mental health and/or alcohol and/or drug abuse treatment providers and/or physical health providers.

Executed this _____day of _____, 20____.

_____ _____

Signature of Client Signature of Witness

_____

Signature of Parent, Guardian, or Authorized Representative, if required

The person signing this authorization is entitled to a copy.

TO PERSON RECEIVING THE CONFIDENTIAL INFORMATION: PROHIBITION OF REDISCLOSURE

Federal and state law protects the confidentiality of the information disclosed to you related to the individual's alcohol and drug abuse treatment. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Disclosure is limited to the purpose and persons included on the authorization form. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. State laws may also protect the confidentiality of the client's records.

TO THE INDIVIDUAL FILLING THIS OUT:

You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method of asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact NorthSTAR. You can write to NorthSTAR at 1199 S. Beltline Rd., Coppell, Texas 75019. You can also call the NorthSTAR Helpline at 1-972-906-2500.

B.5 Authorization to Release Confidential Information (2 Pages) (Spanish)

NOMBRE DEL PACIENTE _____

Autorizo a _____, a _____ y a la siguiente persona, agencia o grupo:
(Nombre de la HMO) (Nombre de la BHO)

_____

Proveedor/Agencia/Grupo Dirección Ciudad Estado ZIP

para que divulgue información y expedientes relacionados con mi tratamiento y estado de salud física, mental o de abuso de sustancias a las siguientes personas, agencias, doctores y centros profesionales:

_____

Proveedor/Agencia/Grupo Dirección Ciudad Estado ZIP

La información que se divulgará o intercambiará es, entre otra (marque toda la que sea pertinente):

_____ Historia clínica y física

_____ Documentos de alta y resumen

_____ Documentos del tratamiento de la salud mental y abuso de sustancias

_____ Informes de laboratorio

_____ Documentos del tratamiento de la salud física

_____ Documentos de medicamentos

_____ Información del tratamiento del VIH o de las enfermedades transmisibles

_____ Otra (especifique) _____

Esta divulgación se ha autorizado con el siguiente propósito (marque todos los que sean pertinentes):

_____ Diagnóstico y tratamiento

_____ Coordinación de la atención médica

_____ Pagos del seguro

_____ Otro (especifique) _____

Entiendo que mis expedientes de salud mental y abuso de sustancias están protegidos contra la divulgación bajo la ley federal o estatal. Puedo revocar esta autorización. Esta autorización tiene vigencia hasta que yo la revoque o sesenta (60) días después de que yo haya terminado el tratamiento, lo que suceda primero. Una vez que revoque esta autorización, no se podrá divulgar ninguna información, excepto como lo autorice o lo permita la ley. La copia de archivo se considera equivalente al original.

Se me explicó esta autorización y la firmé por mi propia voluntad:

El día _____ del mes de _____ de 20____.

_____ _____

Firma del cliente **Firma del testigo**

_____

Firma del padre, tutor o representante autorizado, si es necesario

AVISO SOBRE LA DECISIÓN DEL CLIENTE DE NO AUTORIZAR LA DIVULGACIÓN DE INFORMACIÓN:

He revisado el formulario anterior para la divulgación de información y me he negado a autorizar la divulgación de información de salud mental y abuso de sustancias a los proveedores de salud física o de tratamiento de salud mental o contra el abuso de alcohol o drogas.

Firmado este día _____ del mes de _____ de 20____.

_____ _____

Firma del cliente **Firma del testigo**

_____

Firma del padre, tutor o representante autorizado, si es necesario

La persona que firma esta autorización tiene derecho a una copia.

PARA LA PERSONA QUE RECIBE LA INFORMACIÓN CONFIDENCIAL: PROHIBICIÓN SOBRE LA DIVULGACIÓN

Las leyes federales y estatales protegen la confidencialidad de la información que usted recibió sobre el tratamiento del abuso de alcohol y drogas de la persona. Las normas federales (42 CFR Parte 2) le prohiben a usted dar esta información a otra persona a menos que se haya permitido expresamente en un consentimiento escrito de la persona de quien se trata, o de otra manera permitida por dichas normas. La divulgación se limita al propósito y a la persona anotados en el formulario de autorización. Las reglas federales limitan el uso de la información a investigar o enjuiciar penalmente a algún paciente que tiene problemas de abuso de alcohol o drogas. Es posible que las leyes estatales también protejan la confidencialidad de los expedientes del paciente.

PARA LA PERSONA QUE LLENA ESTE FORMULARIO:

Tiene el derecho de hacernos preguntas sobre este formulario. También tiene el derecho de revisar la información que nos da en el formulario. (Hay algunas excepciones). Si la información está incorrecta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Puede encontrarlo en el Título 1 del Código Administrativo de Texas, Secciones 351.17 a 351.23. Para hablar con alguien acerca de esta forma, o para pedir correcciones, haga el favor de comunicarse con NorthSTAR. Puede comunicarse con NorthSTAR escribiendo a 1199 S. Beltline Rd., Coppell, Texas 75019 ó llamando a la Línea de Ayuda de NorthSTAR al 1-972-906-2500.

B.6 Birthing Center Report (Newborn Child or Children) Form 7484

MAIL FORM TO:

Texas Health and Human Services Commission
Data Integrity 952-X
PO BOX 149030
Austin, TX 78714-9030

Date Rec'd in Data Integrity

PURPOSE: This form is to be used by BIRTHING CENTERS ONLY to report the birth of a child of a mother currently eligible under the Medicaid program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future medicaid claims payments. If the child's FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid client number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child's Medicaid claim.

To avoid delay in processing the child's Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Mother's Name (Last, First, MI)		Admission Date (mm/dd/yy)	Mother's Medicaid client No.
Mother's Mailing Address–Street		Mother's D.O.B. (mm/dd/yy)	Mother's Medical Record No.
City, State, ZIP			
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.

Has the mother relinquished her rights to the newborn child? . . . . . ❑Yes ❑No

If "Yes," give date of relinquishment . . . . . _____

Certified Midwife
Birthing Center Name
Birthing Center Address – Street
City, State, ZIP

Certification No C N M 0 0	TPI
Completed By (please type or print)	
Birthing Center Telephone No. ( )	Date Form Mailed

B.7 Child Abuse Reporting Guidelines (2 Pages)

HHSC Child Abuse Screening, Documenting, and Reporting Policy for Medicaid Providers

Each contractor/provider shall comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to investigations of report of child abuse and neglect and the provisions of this HHSC policy. HHSC shall distribute funds only to a contractor/provider who has demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 and this HHSC policy. Contractor/provider staff shall respond to disclosures or suspicions of abuse/neglect of minors [by reporting] to appropriate agencies as required by law.

PROCEDURES

I Each contractor/provider shall adopt this policy as its own.

II Each contractor/provider shall report suspected sexual abuse of a child as described in this policy and as required by law.

III. Each contractor/provider shall develop an internal policy and procedures that describe how it will determine, document, and report instances of abuse, sexual or nonsexual, in accordance with the Texas Family Code, Chapter 261.

REPORTING GENERALLY

I Professionals as defined in the law are required to report not later than the 48th hour after the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

II Nonprofessionals shall immediately make a report after the nonprofessional has cause to believe that the child's physical or mental health or welfare has been adversely affected by abuse.

III A report shall be made regardless of whether the contractor/provider staff suspect that a report may have previously been made.

IV Reports of abuse or indecency with a child shall be made to:

- A Texas Department of Family and Protective Services (DFPS) if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (DFPS Texas Abuse Hotline at 1-800-252-5400, operated 24 hours a day, seven days a week);
- B Any local or state law enforcement agency;
- C The state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred; or
- D The agency designated by the court to be responsible for the protection of children.

V The law requires that the following be reported:

- A Name and address of the minor, if known;
- B Name and address of the minor's parent or the person responsible for the care, custody, or welfare of the child if not the parent, if known; and
- C Any other pertinent information concerning the alleged or suspected abuse, if known.

VI Reports can be made anonymously.

VII A contractor/provider may not reveal whether or not the child has been tested or diagnosed with HIV or AIDS.

VIII If the identity of the minor is unknown (e.g., the minor is at the provider's office to anonymously receive testing for HIV or an STD), no report is required.

REPORTING SUSPECTED SEXUAL ABUSE

I Each contractor/provider shall ensure that its employees, volunteers, or other staff report a victim of abuse who is an unmarried minor under 14 years of age and is pregnant or has a confirmed sexually transmitted disease acquired in a manner other than through perinatal transmission.

II The Texas Family Code, Chapter 261, requires other reporting of other instances of sexual abuse. Other types of reportable abuse may include, but are not limited to, the actions described in:

- A Penal Code, §21.11(a) relating to indecency with a child;
- B Penal Code, §21.01(2) defining "sexual contact";
- C Penal Code, §43.01(1) or (3)-(5) defining various sexual activities; or
- D Penal Code, §22.011(a)(2) relating to sexual assault of a child;
- E Penal Code, §22.021(a)(2) relating to aggravated sexual assault of a child.

III Each contractor/provider may utilize the attached Checklist for HHSC Monitoring for all clients under 14 years of age. The checklist, if used, shall be retained by each contractor/provider and made available during any monitoring conducted by HHSC.

TRAINING

I Each contractor/provider shall develop training for all staff on the policies and procedures in regard to reporting child abuse. New staff shall receive this training as part of their initial training/orientation. Training shall be documented.

II As part of the training, staff shall be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

B.8 Child Abuse Reporting Guidelines, Checklist for HHSC Monitoring

Date: _____

Client's name: _____

Client's age (use this checklist only if the client is under 14): _____

Staff person conducting screening: _____

Each contractor/provider shall ensure that its employees, volunteers, or other staff report a victim of child abuse who is a minor under 14 years of age who has engaged in sexual activity with any individual to whom the minor is not married. Sexual activity would be indicated if the minor is pregnant or has confirmed diagnosis of a sexually transmitted disease acquired in a manner other than through perinatal transmission.

Using the criteria above, did you determine that a report of child abuse is required? _____ Yes _____ No

If "yes," please report and complete the information below.

Report was made: _____ Yes _____ No

Staff person who submitted the report (optional): _____

Date reported: _____

Name of agency to which report was made: _____

DFPS call ID# or law enforcement assigned # (optional): _____

Name of person who received report (optional): _____

Phone number of contact (when applicable): _____

B

Use of the checklist for HHSC monitoring of reporting of abuse of children younger than 14 years of age who are pregnant or have STDs does not relieve contractors or subcontractors of the requirements in Chapter 261, Texas Family Code, to report any other instance of suspected child abuse.

B.9 Claim Status Inquiry (CSI) Authorization Form

This form is for ACUTE CARE providers only.

If you are a Long Term Care provider, contact TMHP's EDI Help Desk at 888-863-3638 to request the correct form.

The following information MUST be completed before you can be granted Claim Status Inquiry (CSI) access.

1. Enter your Production User ID: _____

2. Enter your Production User ID Password: _____

*The TMHP **Production User ID** (Submitter ID) is the electronic mailbox ID used for downloading your Claim Status Inquiry reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.*

3. Select Action:

A ☐ Add Claim Status Inquiry Privileges

B ☐ Revoke Claim Status Inquiry Privileges

4. Enter organization information:

*List the billing Texas Provider Identifier (TPI) and National Provider Identifier (NPI) number(s) you choose to access using the Production User ID given above. **Submit additional copies of this form if you need to add more TPI and NPI numbers.***

Provider Name *Must be the name associated with the TPI Base number listed at right.*	**7–Digit BILLING TPI Base Number** *The first 7 digits of the 9 digit TPI number.**	**10-digit BILLING NPI/API***

***Note:** *Performing TPI and NPI/API numbers do not have Claim Status Inquiry access. Enter only **BILLING** TPI and NPI/API numbers.*

5. Enter Requestor Information:

Name: _____

Title: _____

Signature: _____

Telephone Number: _____ ext. _____

Fax Number: _____ ext. _____

6. Return this form to:

Texas Medicaid & Healthcare Partnership
Attention: EDI Help Desk, MC–B14
PO Box 204270
Austin, TX 78720-4270

Or Fax to
512-514-4228 or 512-514-4230

DO NOT WRITE IN THIS AREA — For Office Use

Input By: _____ Input Date: _____ Mailbox ID: _____

Effective Date_07302007/Revised Date_06012007

B.10 Client Medicaid Identification (Form H3087) (19 Pages)

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2008	610098	40	30	02	123456789	AUGUST 31, 2008

952-X 123456789 40 30 02 030711
JOHN DOE
743 GOLF IRONS
DEL VALLE TX 78617

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JOHN DOE	08-27-1997	M	07-09-2008			✔	✔	✔		✔	✔

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-G1/April 2007

B

FOR THE CLIENT: About your Medicaid ID Form

This is your Medicaid Identification form. A new Medicaid Identification form will be mailed to you each month. Take your most recent Medicaid Identification form with you when you visit your doctor or receive services from any of your health care providers. This form helps health care providers know which services you can receive and to bill Medicaid.

If you receive a letter from HHSC stating that the Medicaid program will not pay for certain health services your provider thinks you need, the letter will inform you of your right to ask for a fair hearing to appeal the denial of services. The letter will tell you whom to call or where you can write to request a hearing.

NOTE: According to state law a recipient of Medicaid automatically gives HHSC his or her right to financial recovery from personal health insurance, other recovery sources and money received as a result of personal injuries, to the extent HHSC has paid for medical services. This allows HHSC to recover the costs of medical services paid by the Medicaid program. Any applicant or recipient who knowingly withholds information regarding any sources of payment for medical services violates state law.

PARA EL CLIENTE: información sobre la forma de identificación de Medicaid

Esta es su forma de Identificación de Medicaid. Se le enviará por correo una nueva forma de Identificación de Medicaid cada mes. Lleve con usted la forma más reciente cuando vaya al doctor o reciba servicios de uno de sus proveedores de atención médica. Esta forma ayuda a los proveedores de atención médica a saber cuáles servicios puede recibir usted y a facturar a Medicaid.

Si recibe una carta de la Comisión de Salud y Servicios Humanos (HHSC) indicando que el programa Medicaid no pagará ciertos servicios de salud que su proveedor cree que usted necesita, la carta le informará de su derecho de pedir una audiencia imparcial para apelar la negación de servicios. La carta le indicará a quién debe llamar o a dónde puede escribir para solicitar una audiencia.

NOTA: según las leyes estatales una persona que recibe Medicaid le otorga automáticamente a la HHSC su derecho a recuperación económica de un seguro de salud personal, otras fuentes de recuperación y dinero que reciba por lesiones personales, hasta en la medida en la que la HHSC haya pagado por servicios médicos. Esto le permite a la HHSC recuperar los costos de servicios médicos pagados por el programa Medicaid. Cualquier solicitante o cliente que a sabiendas retenga información sobre las fuentes de pago por servicios médicos viola la ley estatal.

Get Answers to Your Questions		
Question	**Contact**	**Phone**
Whom can I call to find out which services are paid by Medicaid?	**Medicaid Hotline**	**1-800-252-8263**
Whom can I call if I get a bill from a Medicaid provider?	**Texas Medicaid Healthcare Partnership Client Hotline**	**1-800-335-8957**
Whom should I call if I need help finding or contacting a doctor, dentist, case manager, or other Medicaid provider for someone 21 years old or younger?	**Texas Health Steps**	**1-877-847-8377**
Who can drive me to my Medicaid provider?	**Medical Transportation**	**1-877-633-8747**
Who can help me if I have questions or problems with my health plan, or my Primary Care Case Management (PCCM) doctor?	**STARLINK**	**1-866-566-8989**
If I am receiving help paying my high medical bills and I need information about my case, whom do I call?	**Texas Medicaid Healthcare Partnership Client Hotline**	**1-800-335-8957**
Whom can I call to find out about nursing home care, adult day care or other long-term care services?	**Department of Aging and Disability Services Consumer Rights Hotline**	**1-800-458-9858**
Who can tell me about how my other insurance might affect my Medicaid benefits?	**Texas Medicaid Healthcare Partnership Third Party Resources Hotline**	**1-800-846-7307**
To whom do I report Medicaid fraud, waste or abuse?	**Office of Inspector General**	**1-800-436-6184**
Whom do I talk to about helping me pay my private insurance premiums?	**Health Insurance Premium Program Hotline**	**1-800-440-0493**
Whom do I talk to if I receive supplemental security income and I need to change my address?	**Social Security Administration**	**1-800-772-1213**
Whom do I call if I have questions about my Medicare Rx Prescription Program?	**Medicare**	**1-800-MEDICARE (1-800-633-4227)**

Reciba respuestas a sus preguntas		
Pregunta	Contacto	Teléfono
¿A quién puedo llamar para información sobre que servicios paga el Medicaid?	Línea directa de Medicaid	1-800-252-8263
¿A quién puedo llamar si recibo una cuenta de un proveedor de Medicaid?	Línea Directa del Cliente de Texas Medicaid Healthcare Partnership	1-800-335-8957
¿A quién debo llamar si necesito ayuda para encontrar o comunicarme con un doctor, dentista, administrador de casos u otro proveedor de Medicaid para alguien que tiene 21 años o menos?	Pasos Sanos de Texas	1-877-847-8377
¿Quién me puede llevar a mi proveedor de Medicaid?	Transporte médico	1-877-633-8747
¿Quién me puede ayudar si tengo preguntas o problemas con mi plan de salud o con mi doctor de Primary Care Case Management (PCCM)?	STARLINK	1-866-566-8989
Si estoy recibiendo ayuda para pagar mis cuentas médicas elevadas y necesito información sobre mi caso, ¿a quién llamo?	Línea Directa del Cliente de Texas Medicaid Healthcare Partnership	1-800-335-8957
¿A quién puedo llamar para información sobre la atención en una casa para convalecientes, cuidado de adultos durante el día, u otros servicios de atención a largo plazo?	Línea Directa del Derecho al Consumidor del Departamento de Servicios a Adultos Mayores y Personas Discapacitadas	1-800-458-9858
¿Quién me puede decir como puede afectar mi otro seguro médico mis beneficios de Medicaid?	Línea Directa de Recursos de Terceros de Texas Medicaid Healthcare Partnership	1-800-846-7307
¿A quién le denuncio el fraude, malgasto o abuso de Medicaid?	Oficina de la Fiscalía General	1-800-436-6184
¿Con quién hablo sobre ayuda para pagar mis primas de seguro privado?	Línea Directa del Programa de Primas de Seguro de Salud	1-800-440-0493
¿Con quién hablo si recibo Seguridad de Ingreso Suplementario y necesito cambiar mi dirección?	Administración de Seguro Social	1-800-772-1213
¿A quién llamo si tengo preguntas sobre mi Programa de Medicare Rx para Medicamentos con Receta?	Medicare	1-800-MEDICARE (1-800-633-4227)

Form H3087/Page 2/03-2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

1 ATFF 01-00001

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/05/2008	610098		40	02	123456789	JULY 31, 2008

952-X 123456789 40 02 030731
JANE DOE
743 GOLF IRONS
HUNTINGTON TX 75949

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	12-09-1999	F	06-01-2008			✓	✓	✓		✓	✓

THSTEPS MEDICAL AND DENTAL CHECK-UP DUE / NECESITA SU EXAMEN MEDICO Y DENTAL DE THSTEPS

B

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-G2/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

41 ATFF 01-00041

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		37	02	123456789	JULY 31, 2008

LIMITED

952-X 123456789 37 02 030731
JANE DOE
743 GOLF IRONS
CROCKETT TX 75835

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-05-1997	F	06-01-2008				✓	✓		✓	✓

LIMITED

TO DOCTOR: **
JAMES B SMITH MD **
WEST MEDICAL BLDG. **
111 EAST 18TH AVE. **
AUSTIN TX 78759 **

TO PHARMACY:
HAPPY PHARMACY
11223 WEST 27th

AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PRIMARY CARE PROVIDER AND/OR PHARMACY
Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UN SOLO PROFESIONAL MÉDICO O UNA SOLA FARMACIA
Llame al Programa Limitado a 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-GL/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

15 ATFF 01-00015

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2008	610098	13	13	04	123456789	JULY 31, 2008

MQMB

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
GRANGER TX 76530

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-14-1946	F	09-01-2008		123456789HIC	✔				✔	✔

B

NOTICE TO PROVIDER

This recipient is eligible for regular Medicaid benefits.

This recipient is also eligible for coverage of Medicare deductible and coinsurance liabilities on valid Medicare claims. Coverage is subject to Medicaid reimbursement limitations.

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-GM/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030
RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

8 ATFF 01-00008
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN PARA MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2008	610098	13	14	04	123456789	JULY 14, 2008

Q M B

952-X 123456789 13 14 04 030714
JOHN DOE
743 GOLF IRONS
LAREDO TX 78046

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JOHN DOE	11-30-1962	M	07-01-2008	M	123456789HIC

Q M B

QUALIFIED MEDICARE BENEFICIARIES

NO MEDICARE PRESCRIPTION DRUGS AUTHORIZED. YOU ARE ELIGIBLE FOR MEDICARE RX.

NO SE AUTORIZÓ NINGUNA RECETA MÉDICA DE MEDICARE. USTED LLENA LOS REQUISITOS PARA RECIBIR MEDICARE RX.

Notice to Providers :

THIS CLIENT IS ELIGIBLE FOR QMB BENEFITS ONLY.

This client is eligible only for coverage of Medicare deductible and coinsurance liabilities on valid Medicare claims. Coverage is subject to Medicaid reimbursement limitations.

Form H3087-C1/January 2006

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

41 ATFF 01-00041

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		37	02	123456789	July 31, 2008

EMERGENCY

952-X 123456789 37 02 030731
JANE DOE
743 GOLF IRONS
CROCKETT TX 75835

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-05-1999	F	06-01-2008				✔	✔		✔	✔

B

TO DOCTOR:	**	TO PHARMACY:
JAMES B SMITH MD	**	HAPPY PHARMACY
WEST MEDICAL BLDG.	**	11223 WEST 27th
111 EAST 18TH AVE.	**	
AUSTIN TX 78759	**	AUSTIN TX 78759

Form H3087-EM/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

1 ATFG 01-00001

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2008	610098	13	13	04	123456789	AUGUST 31, 2008

HOSPICE

952-X 123456789 13 13 04 030831
JANE DOE
743 GOLF IRONS
CARROLTON TX 75006

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✓ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	10-28-1944	F	07-01-1999			✔	✔	✔		✔	✔

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-GH/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

191 ATFF 01-00191

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098	13	13	04	123456789	JULY 31, 2008

LIMITED PHARMACY

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77228

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's plan for Medicaid in your county. You have a Primary Care Provider (PCP). Your health plan and PCP are listed under your name. If you have Medicare you will not have a PCP listed.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el plan del estado para Medicaid en su condado. Tiene un Proveedor de Cuidado Primario (PCP). Bajo su nombre aparecen el nombre de su plan de salud y de su PCP. Si usted recibe Medicare, el nombre del PCP no aparecerá.

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS**, por favor, llame al **1-800-964-2777** para conseguir ayuda.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-05-1985	F	10-01-1997			✔	✔	✔		✔	✔
	/			/WELBY MARCUS L MD								

B

LIMITED PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PHARMACY

Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA

Llame al Programa Limitado a 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-P1/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

31 ATFF 01-00031

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2008	610098		42	02	123456789	JULY 31, 2008

P E

952-X 123456789 42 02 030731
JANE DOE
743 GOLF IRONS
RIO BRAVO TX 78046

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	11-08-1995	F	07-14-2008			✔	✔	✔		✔	✔

PRESUMPTIVE ELIGIBILITY

Notice to Providers: This client has been approved for Presumptive Medicaid Eligibility for Pregnant Women until the regular Medicaid determination is made.

Medicaid covered services during the presumptive eligibility period are limited to medically necessary outpatient services and family planning services. Labor, delivery, inpatient services and THSteps medical and dental services are not covered.

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-PE/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030
RETURN SERVICE REQUESTED

190 ATFF 01-00190
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098	13	13	04	123456789	JULY 31, 2008

LIMITED PHARMACY

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77220

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's plan for Medicaid in your county. You have a Primary Care Provider (PCP). Your health plan and PCP are listed under your name. If you have Medicare you will not have a PCP listed.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el plan del estado para Medicaid en su condado. Tiene un Proveedor de Cuidado Primario (PCP). Bajo su nombre aparecen el nombre de su plan de salud y de su PCP. Si usted recibe Medicare, el nombre del PCP no aparecerá.

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS,** por favor, llame al **1-800-964-2777** para conseguir ayuda.
¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1984	F	03-01-1996		

BEST HEALTH PLAN /1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION

LIMITED PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PRIMARY CARE PHARMACY Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA
Llame al Programa Limitado a 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-PL/February 2007

B

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

1 ATFF 01-00001

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098	13	13	04	123456789	JULY 31, 2008

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
LUCAS TX 75002

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?

Please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años or más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?

Por favor, llame al **1-800-964-2777** para conseguir ayuda. ¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE /	04-02-1964 /WELBY	F	11-01-2006 MARCUS	L MD		✔	✔	✔		✔	✔

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-S1/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

184 ATFF 01-00184

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		01	02	123456789	JULY 31, 2008

LIMITED PHARMACY

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77093

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?

Please call 1-800-964-2777 for help.
READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años or más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?

Por favor, llame al **1-800-964-2777** para conseguir ayuda. ¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-04-1984	F	06-01-2007			✔	✔	✔		✔	✔
	/	/WELBY		MARCUS		L MD						

B

LIMITED PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PHARMACY

Call the Limited Program at
1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA

Llame al Programa Limitado a
1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-S2/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

187 ATFF 01-00187

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		01	02	123456789	JULY 31, 2008

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77056

NOTE: Prescription benefits for Medicare clients age 21 and over may be limited to three (3) per month.

NOTA: Puede que los beneficios de recetas para los clientes de Medicare mayores de 21 años se limiten a tres (3) por mes.

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's plan for Medicaid in your county. Your health plan's name and telephone number are listed under your name. Call your health plan for your Primary Care Provider (PCP) name or refer to your health plan identification card. If you have Medicare you will not have a STAR+PLUS PCP.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el plan del estado para Medicaid en su condado. Bajo su nombre aparecen el nombre y el teléfono de su plan de salud. Llame al plan de salud para saber el nombre de su Proveedor de Cuidado Primario (PCP) o vea la tarjeta de identificación del plan. Si usted recibe Medicare, no tendrá un PCP de STAR+PLUS.

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS**, por favor, llame al **1-800-964-2777** para conseguir ayuda.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-04-1984	F	06-01-2007			✔	✔	✔		✔	✔
	/			/WELBY MARCUS L MD								

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-S3/April 2007

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

198 ATFF 01-00198

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		01	02	123456789	JULY 31, 2008

Primary Care Case Management (PCCM)

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77143

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You now receive your Medicaid medical care through Primary Care Case Management (PCCM). Your primary care provider (PCP) is listed below. If you want to pick a different PCP, call toll-free 1-888-302-6688.

Your PCP is your first stop for getting medical care. When you are sick or injured, your PCP will help you. Your PCP can also assist with THSteps checkups for children and teenagers, prenatal and well woman care. For more information, read your handbook, Primary Care Provider and Hospital List, or call PCCM toll-free at 1-888-302-6688.

READ BACK OF THIS FORM!

TODA PERSONA NOMBRADA A CONTINUACIÓN PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted ahora recibe la atención médica de Medicaid por medio de Primary Care Case Management (PCCM). El nombre de su Proveedor de Cuidado Primario (PCP) aparece a continuación. Si quiere escoger a otro PCP, llame gratis al 1-888-302-6688.

Su PCP es el primer lugar al que debe ir para recibir atención médica. Cuando esté enfermo o lesionado, su PCP le ayudará. También le puede ayudar con los chequeos de Pasos Sanos de Texas para niños y jóvenes, con la atención prenatal y los chequeos preventivos para la mujer. Para más información, lea el manual titulado Lista de Proveedores de Cuidado Primario y Hospitales, o llame gratis a PCCM al 1-888-302-6688.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	DENTAL SERVICES	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	02-04-1985	F	07-01-2008			✔	✔	✔		✔	✔
PCCM /1-800-123-4567 / DR. JEREMY IRONS												

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-S4/April 2007

B

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030
RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

185 ATFF 01-00185
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		01	02	123456789	JULY 31, 2008

LIMITED PHARMACY

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77093

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?
Please call 1-800-964-2777 for help.
READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años or más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?
Por favor, llame al **1-800-964-2777** para conseguir ayuda.
¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1984	F	04-01-2008		

BEST HEALTH PLAN /1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION

LIMITED PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PRIMARY CARE PHARMACY
Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA
Llame al Programa Limitado a 1-800-436-6184

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-SL/January 2006

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

192 ATFF 01-00192

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098	13	13	04	123456789	JULY 31, 2008

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77231

NOTE: Prescription benefits for Medicare clients age 21 and over may be limited to three (3) per month.
NOTA: Puede que los beneficios de recetas para los clientes de Medicare mayores de 21 años se limiten a tres (3) por mes.

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's plan for Medicaid in your county. Your health plan's name and telephone number are listed under your name. Call your health plan for your Primary Care Provider (PCP) name or refer to your health plan identification card. If you have Medicare you will not have a STAR+PLUS PCP.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el plan del estado para Medicaid en su condado. Bajo su nombre aparecen el nombre y el teléfono de su plan de salud. Llame al plan de salud para saber el nombre de su Proveedor de Cuidado Primario (PCP) o vea la tarjeta de identificación del plan. Si usted recibe Medicare, no tendrá un PCP de STAR+PLUS.

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS,** por favor, llame al **1-800-964-2777** para conseguir ayuda.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1951	F	06-01-2004		
BEST HEALTH PLAN		**/1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION**				

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-SP/February 2007

B

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030
RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

186 ATFF 01-00186

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2008	610098		01	02	123456789	JULY 31, 2008

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77096

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?

Please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años or más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?

Por favor, llame al **1-800-964-2777** para conseguir ayuda.
¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1982	F	01-01-2008		
BEST HEALTH PLAN		**/1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION**				

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-ST/January 2006

P.O. BOX 149030 952-X
AUSTIN, TEXAS 78714-9030
RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

2 ADEQ 01-00002
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
04/09/2008	012338	41	02		111111111	AUGUST 31, 2008

Women's Health Program

952-X 111111111 41 02 070430
SUSIE Q CITIZEN
11111 MAIN STREET
AUSTIN TX 77777

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR
222222222	SUSIE Q CITIZEN	01-21-1980	F	02-01-2008	

B

You must take this Medicaid Identification form with you when you visit your doctor or receive Medicaid services from any of your health care providers. This form helps health care providers know which services you can receive and how to bill Medicaid. You will receive a new Medicaid Identification form each month while you are eligible for Medicaid services.

You are enrolled in Women's Health Program. If you would like to apply for other Medicaid services, call us toll free at **2-1-1**, Monday through Friday, 8 a.m. to 8 p.m. Central Time.

Notice to Providers

Women's Health Program services covered by Medicaid during the period of eligibility are limited to:

An annual visit and exam.

Contraception, except emergency contraception.

Debe llevar con usted esta forma de identificación de Medicaid cuando vaya al doctor o reciba servicios de Medicaid de uno de sus proveedores de atención médica. Esta forma ayuda a los proveedores de atención médica a saber que servicios puede recibir y cómo cobrarle a Medicaid. Recibirá una nueva forma de identificación de Medicaid cada mes que llene los requisitos para recibir servicios de Medicaid.

Usted está inscrita en el programa Programa de Salud de la Mujer. Si quiere solicitar otros servicios de Medicaid, llámenos gratis al **2-1-1**, de lunes a viernes, de 8 a.m. a 8 p.m. hora central.

Aviso a los proveedores

Los servicios del programa Programa de Salud de la Mujer que cubre Medicaid durante el periodo de elegibilidad están limitados a :

Una visita y un examen anuales.

Anticonceptivos, salvo los anticonceptivos de emergencia.

Form H3087-WH/January 2007

B.11 Credit Balance Refund Worksheet

Provider Name: _____

TPI: _____ NPI: _____

ICN/PCN	Patient Name	Company Name/Address	Policy Number	Group Number	Insurance Paid Amount	Refund Amount

Mail refund checks, made payable to TMHP, along with the "Credit Balance Refund Worksheet" to the following address:

Texas Medicaid & Healthcare Partnership
CBA Worksheets & Refunds
PO Box 202948
Austin TX 78720-9981

B.12 DME Certification and Receipt Form

Go to new form

This certification is required by section 32.024 of the *Human Resources Code* and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client. This is to certify that on (month, day, year).....:

- The client received the .....(equipment) as prescribed by the physician.
- The equipment has been properly fitted to the client and/or meets the client's needs.
- The client, the parent or guardian of the client, and/or the primary caregiver of the client, has received training and instruction regarding the equipment's proper use and maintenance.

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

.....

Signature of DME Supplier

Signature of Client/Parent/Guardian/ Primary Caregiver

Certificación y recibo de equipo médico duradero (DME)

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de poder reembolsar al proveedor del equipo médico duradero por cualquier equipo médico proporcionado al cliente de Medicaid. Esto certifica que el: (mes, día, año).....

- El cliente recibió [el] [la] [los] [las] .....(equipo) que el doctor recetó.
- El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.
- El cliente, su padre o tutor, o el cuidador principal del cliente, ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

.....

Firma del Proveedor del Equipo Médico Duradero

Firma del Cliente, Padre, Tutor o Cuidador principal

B

B.13 Donor Human Milk Request Form

Donor Human Milk Request Form (Must be Reordered Every 180 Days)			
Client Name:		Client Medicaid Number:	
Date of birth:		Client's weight:	
Parts A and B must be completed and copies retained in both the physician's and the milk bank's records. These forms and clinical records are subject to retrospective review.			
Part A			
The physician must keep up-to-date documentation of medical necessity and the signed written consent form in the child's clinical record to be considered for Medicaid reimbursement.			
☐ The medical necessity for breast milk* is: Child's diagnosis:			
Date of last feeding trial: / /			
Reason donor milk is the only appropriate source of human milk for this client:			
*This information must be substantiated by written documentation in the clinical record of why the particular infant cannot survive and gain weight on any appropriate formula, such as an elemental formula or enteral nutritional product, other than donor human breast milk, and that a clinical feeding trial has occurred every 180 days.)			
☐ The parent/guardian has signed and dated an informed consent that the risks and benefits of using banked donor human milk has been discussed with them.			
Dates of service requested	From:	To:	Quantity Requested:
Physician's Signature:		Date: / /	
Physician Name:		Physician's Fax Number:	
License Number:	TPI:	NPI:	
Part B			
The particular donor human milk bank adheres to quality guidelines consistent with the Human Milk Banking Association of North America, or other standards established by HHSC. Yes ☐ No ☐			
Milk Bank Name:		Milk Bank Fax Number:	
Milk Bank Address:			
Milk Bank Representative Signature		Date: / /	
Milk Bank Representative's Name:		TPI:	
NPI:	Taxonomy:	Benefit Code:	

Effective Date_07302007/Revised Date_6012007

B.14 Electronic Funds Transfer (EFT) Information

Electronic Funds Transfer (EFT) is a payment method to deposit funds for claims approved for payment directly into a provider's bank account. These funds can be credited to either checking or savings accounts, provided the bank selected accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, ***ensuring funds are directly deposited into a specified account.***

The following items are specific to EFT:

- Pre–notification to your bank takes place on the cycle following the application processing.
- Future deposits are received electronically after pre–notification.
- The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider's account during the weekly cycle.
- Specific deposits and associated R&S reports are cross–referenced by both the provider identifiers (i.e., NPI, TPI, and API) and R&S number.
- EFT funds are released by TMHP to depository financial institutions each Friday.
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

> *Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Please contact your financial institution regarding posting time if funds are not available on the release date.*
>
> *However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn should work out the best way to serve their customer's needs.*
>
> *In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.*

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. ***You must return the agreement and either a voided check or a statement from your bank written on the bank's letterhead to the TMHP address indicated on the form.***

Call the TMHP Contact Center at 1–800–925–9126 for assistance.

B.15 Electronic Funds Transfer (EFT) Authorization Agreement

*Enter **ONE** Texas Provider Identifier (TPI) per Form*

NOTE: *Complete all sections below and **attach a voided check or a statement from your bank written on the bank's letterhead**.*

Type of Authorization: ☐ **NEW** ☐ **CHANGE**

Provider Name	**Nine–Character Billing TPI**
National Provider Identifier (NPI)/Atypical Provider Identifier (API):	**Primary Taxonomy Code:** **Benefit Code:**
Provider Accounting Address	**Provider Phone Number** **( ) Ext.**
Bank Name	**ABA/Transit Number**
Bank Phone Number	**Account Number**
Bank Address	**Type Account (check one)** ☐ Checking ☐ Savings

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its health insuring contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

Authorized Signature _____ **Date** _____

Title _____ **Email Address (if applicable)** _____

Contact Name _____ **Phone** _____

Return this form to:
Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin TX 78720–0795

DO NOT WRITE IN THIS AREA — For Office Use

Input By: **Input Date:**

B.16 External Insulin Pump

Client Name:	Date of birth: / /	Medicaid number:
Physician Information		
Name :	Physician specialty:	
Telephone:	Fax number:	License number:
TPI:	NPI:	

The following information is the minimum documentation required for consideration of medical necessity and must be submitted with a completed and signed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

1. Lab values: current and past blood glucose levels, and glycosylated hemoglobin (Hb/A1C) levels—note date of lab draws

2. Client history of severe glycemic excursions, brittle diabetes, hypoglycemic/hyperglycemic reactions, nocturnal hypoglycemia, any extreme insulin sensitivity, and/or very low insulin requirements

3. Client history of any wide fluctuations in blood glucose level before mealtimes

4. Client history of any dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL

5. Day-to-day variations in client's work/school schedule, mealtimes and/or activity level, which require multiple insulin injections

6. For purchase after the initial trial period a statement of client's compliance and effectiveness of the pump is required

Physician signature:	Date: / /

Effective Date_07302007/Revised Date_06012007

B.17 Federally Qualified Health Center Report (Newborn Child or Children) Form 7484

Texas Health and Human Services Commission
Data Integrity 952-X
PO Box 149030
Austin, TX 78714-9030

Date Rec'd in Data Integrity

PURPOSE: This form is to be used by FEDERALLY QUALIFIED HEALTH CENTERS ONLY to report the birth of a child of a mother currently eligible under the Medicaid program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future medicaid claims payments. If the child's FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid client number of the newborn child, please complete this document and submit it to the HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child's Medicaid claim.

To avoid delay in processing the child's Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Mother's Name (Last, First, MI)		Admission Date (mm/dd/yy)	Mother's Medicaid Recipient No.
Mother's Mailing Address–Street		Mother's D.O.B. (mm/dd/yy)	Mother's Medical Record No.
City, State, ZIP			
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.

Has the mother relinquished her rights to the newborn child? . . . . . ❑Yes ❑No

If "Yes," give date of relinquishment . . . . . _____

Child's Attending Physician
Certified Midwife
Health Center Name
Health Center Address – Street
City, State, ZIP

Physician's Medical Lic. No. TXB	TPI
Certification No CNM00	TPI

Completed By (please type or print)	
FQHC Telephone No. ( )	Date Form Mailed

B.18 Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)

Name (Last, First, Middle Initial)		Client No.	Age	Birth Date
Address (Street, City, State, ZIP Code)				
Date of Examination	Place of Examination	Puretone Audiometry: ANSI 1969 ❑ Yes ❑ No		
Date of Calibration	Ambient Noise** _____dBa_____dBc	**Ambient noise level measurements MUST be made at the time of EACH evaluation not conducted in a commercially sound treated facility		

Indicate with an asterisk (*) by Recorded Threshold when masking is used

AIR CONDUCTION SOUND FIELD TEST RESULT IN DECIBELS
(Completed by physicians and audiologist only)

	500 Hz	1000 Hz	2000 Hz	4000 Hz
LE				
RE				
Masking Level LE				
Masking Level RE				

BONE CONDUCTION

	500 Hz	1000 Hz	2000 Hz	4000 Hz
LE				
RE				
Masking Level LE				
Masking Level RE				

SPEECH AUDIOMETRY

	SRT	PB Quiet	PB Level	Thres. Disc.
LE				
RE				
Masking Level LE				
Masking Level RE				

FITTING AND DISPENSING RESULTS

	UNAIDED	AIDED AID 1 LE	AIDED AID 1 RE	AIDED AID 2 LE	AIDED AID 2 RE	OPTIONAL LE	OPTIONAL RE
Make							
Model							
Gain/Volume							
SAT							
SRT							
PB Quiet							
PB Level							
PB Noise**							
PB Level							
Noise Level							
MCL							
Discomfort							
Dynamic Range							

**Specify type of noise used _____

Ear Fitted p R p L Acquisition Cost_____

Manufacturer_____

Model_____

Comments:

Is report of Physician's Examination attached? ❑ Yes ❑ No

FITTER AND DISPENSER: The fitter and dispenser must sign below.

_____
Name of Fitter and Dispenser (please type or print)

_____
Signature – Fitter and Dispenser Date

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

I, _____ do hereby certify that I am _____ and that
(Signature of Physician or Audiologist) (Title of Person Certifying)

I am duly authorized to make this certification for and on behalf of _____
(Name of Payee Company Claimant)

I further certify that the attached invoice is correct and that it corresponds in every particular with the supplies and/or services contracted for. I further certify that the account is true, correct and unpaid.

_____
(Signature of Physician or Audiologist) Date

_____

B

B.19 Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)

Page 1 of 2

General Instructions

This form must be completed and signed as outlined in the instructions below before DME/medical supplies providers contact TMHP Home Health Services for prior authorization.

Either the DME supplier/Medicaid provider or the prescribing physician may initiate the form. This completed form must be retained in the records of both the DME supplier/medical provider and the prescribing physician, and is subject to retrospective review. This form becomes a prescription when the physician has signed section B.

Note: *This form cannot be accepted beyond 90 days from the date of the prescribing physician's signature.*

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer's suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

All fields must be filled out completely. The prescribing physician's TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Section A: Requested Durable Medical Equipment and Supplies

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer's suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

Requested Durable Medical Equipment and Supplies

Item number	HCPCS Code	Quantity	Price
1	J-E1399	1	$50.00
2	J-E1220	1	$2500.00
3			
4			
5			

Examples of Supplies

Item number	HCPCS Code	Quantity	Price
1	9-A4253	2 boxes	N/A
2	9-A4259	1 box	N/A
3	9-A4245	1 box	N/A
4			
5			

Physicians must indicate their professional license number. If the prescribing physician is out of state, the physician must provide the license number and state of professional licensure. Texas Medicaid TPI and UPIN numbers are not acceptable as licensure. The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must be used when prescribing more than 5 items. The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must accompany *the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form*.

Note: *Addendums received without this form will not be accepted.*

Reminder: *Home health services are not a benefit for clients residing in a nursing facility, hospital, or intermediate care facility.*

Note for DME: *The DME company must also complete the DME Certification and Receipt Form. All equipment is to be assembled, installed, and used pursuant to the manufacturer's instructions and warning.*

Effective Date_07302007/Revised Date_06252007

Page 2 of 2

Section B: Diagnosis and Medical Information

Section B is a prescription for DME/supplies and must be filled out by the prescribing physician.

The prescribing physician must indicate the ICD-9 code with a brief description, corresponding to the item number requested from Section A and complete justification for determination of medical necessity for the requested item(s). If applicable, include height/weight, wound stage/dimensions and functional/mobility.

Note: *The date last seen must be within the past 12 months.*

The prescribing physician must indicate the duration of need for the prescribed supplies/DME. The estimated duration of need should specify the amount of time the supplies/DME will be needed, such as six weeks, three months, lifetime, etc. The prescribing physician's TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Note: *Signatures from nurse practioners, physician assistants, and chiropractors will not be accepted. Signature stamps and date stamps are not acceptable.*

Diagnosis and Medical Need Information

ICD-9	Requested Section A No.[2]	Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.[1,2]
438	1,2	Unable to get in and out of the tub or shower
27801	2	Need swing-away arms and legs for transfer secondary to hemiparesis and need oversize chair for clients weighing 400 lbs.

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

Examples of Supplies

ICD-9	Requested Section A No.[2]	Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.[1,2]
25001	3,4,5	

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

Effective Date_07302007/Revised Date_06252007

B.20 Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician's signature. Fax completed form to 1-512-514-4209.

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): ☐ Requesting Physician ☐ Supplier

Client name:	Client date of birth: / /
Client Medicaid number:	Is client under 21 years of age? YES ☐ NO ☐

Supplier name:	Supplier address:	
Supplier telephone:	Supplier Fax:	Supplier TPI:
Supplier NPI:	Supplier Taxonomy:	Supplier Benefit Code:
Physician name:	Physician telephone:	Physician Fax:

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DME/medical supplies provider representative signature:	Date: / /

DME/medical supplies provider representative name (Typed or Printed):

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?	Beyond quantity limit?[1]	Custom item?[1]
1					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
2					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
3					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
4					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
5					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

☐ Check if additional documentation is attached as outlined in the TMPPM.

Is the DME Provider Medicare certified? YES ☐ NO ☐	If yes, indicate Medicare number:

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

ICD-9	Brief Diagnosis Descriptor	Requested Item Number from Section A[2]	Complete justification for determination of medical necessity for requested item(s)[2] (Refer to Section A, footnote 1)
__ __ __ . __ __			
__ __ __ . __ __			
__ __ __ . __ __			
__ __ __ . __ __			

2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification. Enter all Item numbers from the table in Section A that pertain to each diagnosis.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status in table below.

Height	Weight	Wound stage/dimensions	Functionality/mobility status

***Note**: The "Date last seen" and "Duration of need" items below **must** be filled in.*

Date last seen by physician: / /

Duration of need for DME: _____ month (s)	Duration of need for supplies: _____ month (s)

By signing this form, I hereby attest that the information completed in Section "A" is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician:	Date: / /

Signature stamps and date stamps are not acceptable

Prescribing physician's license number:

Prescribing physician's TPI:	Prescribing physician's NPI:

☐ Check if all of the information in Section A was complete at the time of the prescribing provider signature

Effective Date_07302007/Revised Date_06012007

B.21 Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): ☐ Requesting Physician ☐ Supplier

Client name:	Client date of birth: / /
Client Medicaid number:	Is client under 21 years of age? Yes ☐ No ☐

Supplier Information

Name:	Telephone:	Fax number:
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	

Prescribing Physician Information

Name:	Telephone:	Fax number:

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DME/medical supplies provider representative signature:	Date: / /

DME/medical supplies provider representative name (Typed or Printed):

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?	Beyond quantity limit?[1]	Custom item?[1]
6					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
7					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
8					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
9					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
10					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
11					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
12					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
13					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
14					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
15					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
16					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
17					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
18					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
19					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
20					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
21					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
22					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
23					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
24					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
25					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
26					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

☐ Check if additional documentation is attached as outlined in the TMPPM.

Is the DME Provider Medicare certified? YES ☐ NO ☐	If yes, indicate Medicare number:

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

By signing this form, I hereby attest that the information completed in Section "A" is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician:	Date: / /

Signature stamps and date stamps are not acceptable

Prescribing physician's license number:	
Prescribing physician's TPI:	Prescribing physician's NPI:

☐ Check if all of the information in Section A was complete at the time of the prescribing provider signature

Effective Date_07302007/Revised Date_06012007

B

B.22 Home Health Services Plan of Care (POC) Instructions

Use the guidelines below in filling out the Home Health Plan of Care (POC) form.	
Client Information	
Client's name	Last name, first name, middle initial
Date of birth	Date of birth given by month, day and year
Date last seen by doctor	Client must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment
Medicaid number:	Nine-digit number from client's current Medicaid identification card.
Home Health Agency Information	
Name	Name of Home Health agency
License number	Medical license number issued by the state of Texas
Address	Agency address given by street, city, state and ZIP code
Telephone	Area code and telephone number of agency
TPI	Texas Provider Identifier number (10-digit) of agency
NPI	National Provider Identifier number (10-digit) of agency
Taxonomy	Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency
DME TPI	Texas Provider Identifier number (10-digit) of agency DME
Benefit Code	Code identifying state program for the service provided
Physician Information	
Name	Name of Physician
License number	Physician's medical license number issued by the state of Texas
Telephone	Area code and telephone number of physician
TPI	Texas Provider Identifier number (10-digit) of physician
NPI	National Provider Identifier number (10-digit) of physician
Plan of Care Information	
Status	Indicate with a check mark if POC is for a new client, extension (services need to be extended for an additional 60 day period) or a revised request
Original SOC date	First date of service in this 365 day benefit period
Revised request effective date	Date revised services, supplies or DME became effective
Services client receives from other agencies	List other community or state agency services client receives in the home. Examples: primary home care (PHC), community based alternative (CBA), etc.
Diagnoses	Diagnosis related to ordered home health services. For reimbursement, diagnoses must match those listed on the claim and be appropriate for the services ordered (Include ICD-9 code if PT/OT is ordered)
Functional Limitations/ Permitted Activities	Include on revised request only if pertinent
Prescribed medications	List medications, dosages, routes, and frequency of dosages (Include on revised request if applicable)
Diet Ordered	Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (Include on revised request if applicable)
Mental Status	Examples: alert and oriented, confused, slow to learn, etc. (include on revised request if applicable)
Prognosis	Examples: good, fair, poor, etc. (include on revised request if applicable)
Rehabilitation potential	Potential for progress, examples: good, fair, poor, etc. (include on revised request if applicable)
Safety precautions	Examples: oxygen safety, seizure precautions, etc. (include on revised request if applicable)
Medical necessity, clinical condition, treatment plan	Describe medical reason for all services ordered, nursing observations pertinent to the plan of care, and the proposed plan of treatment. For PT, list specific modalities and treatments to be used.
SNV, HHA, PT, OT visits requested:	State the number of visits requested for each type of service authorized
Supplies	List all supplies authorized
DME	List each piece of DME authorized, check whether DME is owned, if DME is to be repaired, purchased, or rented, and for what length of time the equipment will be needed
RN signature	The signature and date this form was filled out and completed by the RN
From and To dates	Dates (up to 60 days) of authorization period for ordered home health services
Conflict of Interest Statement	Relevant to the physician signing this form; physician should check box if exception applies.
Physician signature, Date signed, Printed physician name	The physician's signature and the date the form was signed by the physician ordering home health services, and the physician's printed name

Effective Date_07302007/Revised Date_06292007

B.23 Home Health Services Plan of Care (POC)

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

Client's name:			Date of birth: / /	
Date last seen by doctor: / /			Medicaid number:	
Home Health Agency Information				
Name:	Fax number:		Telephone:	
Address:				
TPI:	NPI:		Taxonomy:	
DME TPI:		Benefit Code:		
Physician Information				
Name:			Telephone:	
TPI:	NPI:		License number:	
Status (check one):	New client ☐	Extension ☐	Revised Request ☐	
Original SOC date: / /		Revised request effective date: / /		
Services client receives from other agencies:				
Diagnoses (include ICD-9 codes if PT/OT is ordered):				
Function Limitations/Permitted Activities/Homebound Status:				
Prescribed medications:				
Diet ordered:		Mental status:		
Prognosis:		Rehabilitation potential:		
Safety Precautions:				
Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):				
SNV visits requested:				
HHA visits requested:				
PT visits requested:				
OT visits requested:				
Supplies:				
DME Item No. 1	Own ☐	Repair ☐	Buy ☐	Rent ☐ How long is this DME item needed?
DME Item No. 2	Own ☐	Repair ☐	Buy ☐	Rent ☐ How long is this DME item needed?
DME Item No. 3	Own ☐	Repair ☐	Buy ☐	Rent ☐ How long is this DME item needed?
DME Item No. 4	Own ☐	Repair ☐	Buy ☐	Rent ☐ How long is this DME item needed?
RN signature:			Date signed: / /	
I anticipate home care will be required:	From: / /		To: / /	

Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program.
Check if this exception applies.

☐ Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

Physician signature:	Date signed: / /

Effective Date_07302007/Revised Date_06292007

B

B.24 Home Health Services Prior Authorization Checklist

Contact Medicaid Home Health Services at 1-800-925-8957

To facilitate the authorization process, the home health agency nurse should have completed the following tasks before contacting TMHP for prior authorization of home health services:

- Completion of this optional form
- Evaluation of the client in the home (preferably by the same nurse requesting services)

PLEASE DO NOT SUBMIT THIS FORM TO TMHP.

Date:_____ Agency Nurse Name:_____
Client Medicaid Number:_____ Client Name: _____
Client Medicare Number:_____ Date Last Seen by Physician: _____
Start of Care Date:_____ Date of Last Hospitalization:_____
Date of Home Evaluation: _____
Diagnoses:_____
_____
(If PT is requested, please provide ICD-9-CM diagnosis codes)
Skilled Nursing functions to be provided: _____
_____
_____
_____
Pertinent Nursing Observations (prior teaching, size and descriptions of wounds, functional limitations, etc.): _____
_____
_____
Observations of home setting that may effect care (i.e., cleanliness, availability of running water, electricity and refrigeration, etc.): _____
_____
_____
Availability and capability of caregiver(s): _____
_____
Services client receives from other sources (i.e., Primary Home Care): _____
_____
Services Requested: ___ Skilled Nursing Frequency _____
___ Home Health Services Aide Frequency _____
___ Physical Therapy Frequency _____
___ DME_____ Repair _____Rent _____ Purchase
_____Bid #1
_____Bid #2
___ Supplies: _____
TMHP Nurse: _____ PAN: _____

B.25 Hospital Report (Newborn Child or Children) HHSC Form 7484

Texas Health and Human Services Commission
Data Integrity 952-X
PO BOX 149030
Austin TX 78714-9030

Date Rec'd in Integrity Control

PURPOSE: This form is to be used by HOSPITALS ONLY to report the birth of a child of a mother currently eligible under the Texas Medicaid Program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future Medicaid claims payments. If the child's FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid Recipient number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child's Medicaid claim.

To avoid delay in processing the child's Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Mother's Name (Last, First, MI)		Admission Date (mm/dd/yy)	Mother's Medicaid Recipient No.
		| | | | | |	| | | | | | | | | |
Mother's Mailing Address – Street		Mother's D.O.B. (mm/dd/yy)	Mother's Medical Record No.
		| | | | | |	| | | | | | | | | |
City, State, ZIP			
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy) | | | | | |	Child's Medical Record No. | | | | | | | | | |
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy) | | | | | |	Child's Medical Record No. | | | | | | | | | |
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy) | | | | | |	Child's Medical Record No. | | | | | | | | | |

Has the mother relinquished her rights to the newborn child? . . . . . ❑ Yes ❑ No

If "Yes," give date of relinquishment . . . . . _____

Child's Attending Physician
Hospital Name
Hospital Address—Street
City, State, ZIP

Physician's Medical License No.	TPI
T| X| B| | | | | | |	| | | | | | | | | |
Completed By (please type or print)	
Hospital Telephone No. ( )	Date Form Mailed | | | | | |

B.26 Hysterectomy Acknowledgment Form

MEDICAID CLIENT IDENTIFICATION NUMBER _/_/_/_/_/_/_/_/_/_

Hysterectomy Acknowledgment

I hereby acknowledge that I was, prior to surgery _____ (month, day, year), informed both orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom that procedure is performed permanently incapable of bearing children.

_____ _____

Signature of Client or Designated Representative Date

Reconocimiento

Yo afirmo haber sido informada verbalmente y por escrito, antes de la cirugía _____ (mes, día, año) que una histerectomía (extracción quirúrgica del útero) dejará a la persona a la cual se haya operado permanentemente, incapaz de tener hijos.

_____ _____

Firma del Cliente o Representante Designado Fecha

Interpreter's Statement

To be used if an interpreter is provided to assist the individual having the hysterectomy.
I have translated to the individual having a hysterectomy the information and advice presented orally by the individual obtaining consent. I have also read the consent form to _____ in _____ language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

_____ _____

Signature of Interpreter Date

Revised 8/22/95

B.27 Informational Inquiry Form

Client Information	
Today's date: / /	Medicaid number:
Date of birth: / /	Social Security Number:
Last name:	First name:

Accident Information	
Date of loss: / /	Type of accident:
Case comments:	

Attorney Information		
Name:	Contact name:	
Street Address:		
City:	State:	Zip Code:
Telephone:	Fax number:	

Insurance Information		
Company name:	Contact name:	
Street Address:		
City:	State:	Zip Code:
Telephone:	Fax number:	
Insurance claim number:		

Provider Information		
Name:	Telephone:	
Street Address:		
City:	State:	Zip Code:
TPI:	NPI:	
Taxonomy:	Benefit Code:	

Mail completed copy to:
HHSC/OIG/TPR Unit
INFOC
PO Box 85200
Mail Code 1354
Austin, TX 78708-5200

Effective Date_01152008/Revised Date_06122007

B

B.28 Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Initial Request

Section A: To be completed by the physician or physician staff		
Client Information		
Name:	Medicaid number:	
Primary diagnosis:		
Client respiratory diagnosis:		
Physician Information		
Name:	Telephone:	Fax number:
Address:		
License number:	TPI:	NPI:

Section B: To be completed by the physician			
Device requested	☐ High frequency chest wall compression system (HFCWCS)		
	☐ Intrapulmonary percussive ventilation Device (IPV)		
	☐ Cough stimulating device (cofflator)		
☐	Client had respiratory illness or complication in the past 6 months (provide additional information in narrative section, i.e., nebs for respiratory secretions, I.V. antibiotics, hospitalizations).		Yes ☐ No ☐
☐	Client or family unable to do chest physiotherapy (provide medical reasons in narrative section).		Yes ☐ No ☐
☐	Client has tried other modes of chest physiotherapy, including the use of electrical percussor therapy or flutter valve for a minimum of four months prior to the request and that the therapy has been ineffective (provide information on other therapies and why they are ineffective in narrative section).		Yes ☐ No ☐
☐	Device use has not resulted in, nor exacerbated any gastrointestinal, manifestations, aspiration, pulmonary manifestation, nor seizure activity.		Yes ☐ No ☐
☐	Client had pulmonary function studies in last 6 months, if applicable (provide results in narrative section).		Yes ☐ No ☐
☐	Client has frequently missed work, school or extracurricular activities in the last 6 months due to respiratory illnesses and ineffective chest physiotherapy (provide medical reasons in narrative section).		Yes ☐ No ☐

Clients can have only one chest physiotherapy device at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the Texas Medicaid (Title XIX) Home Health Services section of the Texas Medicaid Provider Procedures Manual.

Section C: The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.	
Narrative note for medical necessity (write legibly):	
Physician signature:	Date: / /
Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form	

Effective Date_07302007/Revised Date_06012007

B.29 Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Extended Request

Section A: To be completed by the physician or physician staff		
Client Information		
Name:	Medicaid number:	
Primary diagnosis:		
Respiratory diagnosis:		
Physician Information		
Name:	Telephone:	Fax number:
License number:	TPI:	NPI:

Section B: To be completed by the physician			
Device requested	☐ High frequency chest wall compression system (HFCWCS)		
	☐ Intrapulmonary percussive ventilation Device (IPV)		
	☐ Cough stimulating device (cofflator)		
☐	Client had respiratory illness or complications **since** initial authorization (include additional information in narrative section, i.e., nebs for respiratory secretions, I.V., antibiotics, and hospitalizations).		Yes ☐ No ☐
☐	Physicians description/assessment of the effectiveness indicates decreased medication use, shorter hospital length of stay (LOS), decreased hospitalizations, and fewer school, work, or extracurricular activity absences due to diagnosis related complications.		Yes ☐ No ☐
☐	System has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestation, nor an exacerbation of seizure activity.		Yes ☐ No ☐
☐	Client has been **compliant** in use of device (document minutes logged per treatment, times per day of treatments, and number of days used for entire trial period).		Yes ☐ No ☐
☐	Client has achieved the desired health outcome with device.		Yes ☐ No ☐

Clients can have only one chest physiotherapy device at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the Texas Medicaid (Title XIX) Home Health Services section of the Texas Medicaid Provider Procedures Manual.

Section C: The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.	
Narrative note for medical necessity (write legibly):	
Physician signature:	Date: / /
Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form	

Effective Date_07302007/Revised Date_06012007

B.30 Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy

Section A - (To Be Completed By Physician or Physician's Staff)			
Client Name:		Client Medicaid Number:	
Physician Information			
Name:		Telephone:	
Address:			
License Number:	TPI:		NPI:
Supplier Information			
Name:		Contact Person:	
Address:			
Telephone:		Fax number:	
TPI:		NPI:	
Taxonomy:		Benefit Code:	
SECTION B- (To Be Completed By Physician)			
CPAP/BIPAP S Request			
Diagnosis:			
Date of Polysomnogram: (Polysomnogram required for all CPAP requests) / /			
If request is for BIPAP, explanation of the inability to tolerate CPAP:			
AHI/RDI:	Sleep Time (hours):	Total Apneas:	
Obstructive apneas:		Lowest Oxygen Saturation (percent):	
BIPAP ST Request			
Diagnosis:			
If request is for BIPAP ST, explanation of the inability to tolerate BIPAP S:			
Date of Polysomnogram (If Applicable): / /			
Lowest Oxygen Saturation (percent): or Arterial PO2 (mm Hg):			
If prescribed for central sleep apnea	Central apneas/hr:	Longest central apnea: sec.	
Oxygen Therapy Request			
Diagnosis:			
Lowest Oxygen Saturation at rest or with exercise (percent): or Arterial PO2 (mm Hg):			
Lowest Oxygen Saturation during sleep (percent): or Arterial PO2 (mm Hg):			
Flow rate (l/min.):	Hours of treatment per day (estimated):		
Is oxygen therapy required for mobility within the home?		☐ Yes	☐ No
Is oxygen therapy required for mobility when leaving the home?		☐ Yes	☐ No
Prescribing Physician Signature:		Date: / /	
Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form			

Effective Date_07302007/Revised Date_08062007

B.31 Medicaid Certificate of Medical Necessity for Reduction Mammaplasty

Section A: **To be completed by the physician or physician staff**			
Client Information			
Name:		Medicaid number:	
Height:	Weight:	Date of birth: / /	
Breast size (must include photograph):			
Physician Information			
Name:	Telephone:	Fax number:	
Address:			
Medical license number:	TPI:	NPI:	
Taxonomy:	Benefit Code:		

Section B: **To be completed by the physician**			
☐	Client has evidence of a restrictive pulmonary defect (provide results of pulmonary function studies in narrative section).		Yes ☐ No ☐
☐	Client has evidence of severe neck and back pain (provide results of therapies tried in narrative section).		Yes ☐ No ☐
☐	Client has evidence of ulnar paresthesia from thoracic nerve root compression (provide results of therapies tried in narrative section).		Yes ☐ No ☐
☐	Client has evidence of ischemic heart disease (provide results of abnormal EKG and/or coronary angiography).		Yes ☐ No ☐
☐	This client, if age 40 or over, has had a mammogram within the past year that was negative for cancer.		Yes ☐ No ☐
☐	Estimated the grams of breast tissue to be removed from each breast.	Right:	Left:
☐	The client is in a weight reduction program and has lost _____lbs.		Yes ☐ No ☐

Section C: **Physician prescribing Reduction Mammaplasty must complete narrative information regarding the medical necessity as requested above.**	
Narrative note for medical necessity (write legibly):	
Physician signature:	Date: / /
Refer to the Reduction Mammaplasty policy in the Physician section of the *Texas Medicaid Provider Procedures Manual*.	

Effective Date_07302007/Revised Date_06012007

B

B.32 Medical Necessity for In-Home Total Parenteral Hyperalimentation (TPN)

Section A: To be completed by the provider

Client Information

Name:	Medicaid number:	
Date of birth: / /	Height: feet inches	Weight: lbs.

Physician Information

Name:	Fax number:	Telephone:
Address:	License number:	

Provider Information

Name:	Address:
Telephone:	Fax number:
TPI:	NPI:
Taxonomy:	Benefit Code:

Home Health Agency Information

Name:	Telephone:	Fax number:
Address:	RN contact name:	

Section B: *Must* be completed by the physician prescribing TPN

Date TPN Started : / /	Estimated length of need (1–99 months, 99 months infers lifetime need):	
Diagnosis codes (expand on this in Section C narrative notes):		
Frequency of labs:	Hours per day of infusion:	Number of days per week of infusion:
Frequency of registered nurse (RN) home visits:		
Usual lab ordered (attach latest lab results, include CA++, K+, LFT, albumin):		
TPN prescription:	Percent of daily nutritional needs from TPN:	
Client is able to take any oral nutrition/supplements: Yes ☐ No ☐	Client receives enteral tube feedings: Yes ☐ No ☐ (attach TPN formula prescription)	

Section C: The physician prescribing TPN must complete narrative information on medical necessity. If pertinent, include documentation on trials with oral/enteral feedings.

Narrative notes for medical necessity:

Physician signature:	Date / /

Effective Date_01152008/Revised Date_11162007

B.33 Nursing Addendum to Plan of Care (THSteps-CCP) (7 Pages)

Client name:	Medicaid number:	Date: / /

Documentation Requirements

All of the following documents must be complete and received by Texas Medicaid Healthcare Partnership (TMHP) before review or authorization of PDN services can occur:

1. All components of the Nursing Addendum to Plan of Care (THSteps-CCP) completed and submitted with
2. The Home Health Plan of Care (POC) form, and
3. THSteps-CCP Prior Authorization Request Form (*additional information may be attached*).

☐ If the client is under 18 years of age, he/she must reside with an identified responsible adult/parent/guardian who is either trained to provide nursing care, or is capable of initiating an identified contingency plan when the scheduled PDN or qualified aide is unexpectedly unavailable.

Name:	Relationship:	Telephone:

☐ The client has an identified contingency plan.

☐ The client has a primary physician who provides ongoing health care and medical supervision.

☐ The place(s) where PDN services will be delivered supports the health and safety of the client.

☐ If applicable, there are necessary backup utilities, communication, fire, and safety systems available and functional.

1. Nursing Care Plan Summary

PDN services are based on a nursing assessment and nursing care plan established by the nurse provider in collaboration with the physician, client, and family. The nursing care plan provides a systematic way to document care given, client responses to interventions, and progress toward the goals of care.

Problem list:

Goals of care:

Specific measurable outcomes:

Progress toward goals:

Additional comments:

Effective Date_09012007/Revised Date_08142007

B

Client name:	Medicaid number:	Date: / /

2. Summary of Recent Health History—For initial authorization or 90-day summary for extension of PDN services

Include recent hospitalizations, emergency room visits, surgery (may submit a discharge summary), illnesses, changes in condition, changes in medication or treatment, parent/guardian update, other pertinent observations.

3. Rationale for PDN Hours—To either increase, decrease, or stay the same. Also address plans to decrease PDN hours.

Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 00:00—05:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.
Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, A=qualified aide, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
00:00														
00:15														
00:30														
00:45														
01:00														
01:15														
01:30														
01:45														
02:00														
02:15														
02:30														
02:45														
03:00														
03:15														
03:30														
03:45														
04:00														
04:15														
04:30														
04:45														
05:00														
05:15														
05:30														
05:45														

Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 06:00—011:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, A=qualified aide, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
06:00														
06:15														
06:30														
06:45														
07:00														
07:15														
07:30														
07:45														
08:00														
08:15														
08:30														
08:45														
09:00														
09:15														
09:30														
09:45														
10:00														
10:15														
10:30														
10:45														
11:00														
11:15														
11:30														
11:45														

Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 12:00—017:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.
Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, A=qualified aide, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
12:00														
12:15														
12:30														
12:45														
13:00														
13:15														
13:30														
13:45														
14:00														
14:15														
14:30														
14:45														
15:00														
15:15														
15:30														
15:45														
16:00														
16:15														
16:30														
16:45														
17:00														
17:15														
17:30														
17:45														

Client name:	Medicaid number:	Date: / /	Client/parent/guardian initials:
List other in-home resources:			

4. Schedule of Services 24-hour Daily Flow Sheet, 18:00—023:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, A=qualified aide, O=other in-home resource(s), specify name above

Military Time	Sunday	Provider	Monday	Provider	Tuesday	Provider	Wednesday	Provider	Thursday	Provider	Friday	Provider	Saturday	Provider
18:00														
18:15														
18:30														
18:45														
19:00														
19:15														
19:30														
19:45														
20:00														
20:15														
20:30														
20:45														
21:00														
21:15														
21:30														
21:45														
22:00														
22:15														
22:30														
22:45														
23:00														
23:15														
23:30														
23:45														

Client name:	Medicaid number:	Date: / /

5. Acknowledgement

Must be signed by the client/parent/guardian and the nurse provider.

By signing this form, the client/parent/guardian and the nurse provider acknowledge:

- Discussion and receipt of information about the THSteps-CCP Private Duty Nursing service,
- PDN services may increase, decrease, stay the same, or be terminated based on a client's need for skilled care,
- PDN is not authorized for respite, child care, activities of daily living, or housekeeping,
- All required criteria from the first page of this addendum are met, and completed documentation is submitted to TMHP,
- Participation in the development of the Nursing Care Plan for this client, and
- Emergency plans are part of the client's care plan and include telephone numbers for the client's physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations.

The client/parent/guardian agrees to follow through with the plan of care as prescribed by the client's physician.

Number of PDN hours requested	Hours per day:	**or**	Hours per week:
Dates of service from:	/ /	**to**	/ /

		/ /
Signature of client/parent/guardian	Printed name	Date
		/ /
Signature of PDN nurse provider	Printed name	Date
		/ /
Signature of prescribing physician	Printed name	Date

B

B.34 Other Insurance Form

Client Name: _____

Client Medicaid Number: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Policy Holder Name: _____

Policy Holder SSN: _____

Employer Name: _____

Group Number: _____

Ins. Eff. Date: _____ Ins. Term. Date: _____

List any family members and their SSN or Medicaid ID numbers that are covered under this policy: _____

_____

_____

COMMENTS: _____

_____

_____

CONTACT: TMHP Third Party Resources (TPR) 1-800-846-7307
TMHP Third Party Resources (TPR) fax 1-512-514-4225

MAIL CORRESPONDENCE: Texas Medicaid & Healthcare Partnership
TPR Correspondence
Third Party Resources Unit
PO Box 202948
Austin, TX 78720-9981

B.35 Primary Care Case Management (PCCM) Behavioral Health Consent Form

DIRECTIONS: This is an authorization for the release of information to your primary care provider.

PLEASE FILL OUT THE INFORMATION BELOW:

I, _____
Name Address

( )
City, State Phone

authorize: _____
Provider Name

to disclose to: _____
Provider Name Address

( )
City, State Phone

from (date) _____ to (date) _____ the following information:

Please indicate what, if any, information you would like to release.

- ☐ Total Medical Records to be released to primary care provider
- ☐ Medication Information **Only** to be released to primary care provider
- ☐ Medical Records to health plan

I understand that my records are protected under Federal (42 CFR Part 2) and/or State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. File copy is considered equivalent to the original. This release of information expires in thirty (30) days or sixty (60) days following completion or termination of treatment, whichever is later.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

EXECUTED THIS _____ DAY OF _____

_____ _____
(Witness) (Patient)

_____
(Parent, Guardian, or Authorized Representative, if required)

The person signing this authorization is entitled to a copy.

TO THE INDIVIDUAL FILLING THIS OUT:
You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method for asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact the Texas Medicaid & Healthcare Partnership (TMHP). You can write to the Texas Medicaid & Healthcare Partnership (TMHP), Attention: State Action Request Support Manager, MC-C04, PO Box 204270, Austin, TX 78720-4270. You can also call the Texas Medicaid & Healthcare Partnership PCCM Client Helpline at 1-888-302-6688.

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION, PROHIBITION ON DISCLOSURE:
If the information disclosed to you is related to substance abuse treatment, these records' confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient's records.

Revised June 12, 2005

B.36 Primary Care Case Management (PCCM) Behavioral Health Consent Form (Spanish)

INSTRUCCIONES. Esta es una autorización para la divulgación de información para su Proveedor de Cuidado Primario.

POR FAVOR, DÉ LA SIGUIENTE INFORMACIÓN:

Yo, _____
Nombre Dirección

( )
Ciudad, Estado Teléfono

autorizo a: _____
Nombre del proveedor

para que le dé a: _____
Nombre del proveedor Dirección

( )
Ciudad, Estado Teléfono

la siguiente información de (fecha) _____ a (fecha) _____ :

Por favor, indique qué información quiere divulgar, si es que quiere divulgar alguna.

☐ Todos los expedientes médicos se pueden divulgar al Proveedor de Cuidado Primario
☐ **Sólo** la información sobre medicamentos se puede divulgar al Proveedor de Cuidado Primario
☐ Los expedientes médicos se pueden divulgar al plan de salud

Entiendo que mis expedientes están protegidos bajo Normas de Confidencialidad Estatales y Federales (42 CFR Parte 2). Esta autorización puede revocarse por escrito en cualquier momento, excepto en el caso en que el programa o la persona que hará la divulgación haya dependido de ella para tomar una acción. Al revocar la autorización, la divulgación adicional de información se detendrá inmediatamente. Las copias de archivo se consideran equivalentes al original. Esta autorización para divulgar información se vence en treinta (30) o sesenta (60) días después de que se termine o se suspenda el tratamiento, el que se llegue después.

También reconozco que se me explicó detalladamente la información que se divulgará y que doy este consentimiento por mi propia voluntad.

FIRMADO ESTE DÍA _____ DE _____

_____ _____
(Testigo) (Paciente)

_____
(Padre, Tutor o Representante Autorizado, si se exige)

La persona que firma esta autorización tiene derecho a una copia.

PARA LA PERSONA QUE LLENA ESTE FORMULARIO:
Tiene el derecho de hacernos preguntas sobre este formulario. También tiene el derecho de revisar la información que nos da en el formulario. (Hay algunas excepciones). Si la información está incorrecta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Puede encontrarlo en el Título 1 del Código Administrativo de Texas, Secciones 351.17 a 351.23. Para hablar con alguien acerca de esta forma, o para pedir correcciones, haga el favor de comunicarse con Texas Medicaid & Healthcare Partnership (TMHP). Puede comunicarse con el personal de Texas Medicaid & Healthcare Partnership (TMHP), Attention: State Action Request Support Manager, MC-C04, PO Box 204270, Austin, TX 78720-4270. También puede llamar a la Línea de Ayuda al Cliente de PCCM, 1-888-302-6688.

PARA LA PERSONA QUE RECIBE LA INFORMACIÓN CONFIDENCIAL: PROHIBICIÓN SOBRE LA DIVULGACIÓN
Si la información que usted ha recibido tiene que ver con el tratamiento para el abuso de sustancias, la ley federal protege la confidencialidad de estos expedientes. Las normas federales (42 CFR Parte 2) le prohiben a usted hacer cualquier otra divulgación de estos expedientes sin el consentimiento escrito específico de la persona de quien se tratan, o de otra manera permitida por dichas normas. Una autorización general para la divulgación de información médica o de otro tipo no es suficiente para divulgar expedientes relacionados con el abuso de sustancias. Las reglas federales limitan el uso de la información a investigar o enjuiciar penalmente a algún paciente de abuso de sustancias. Es posible que las leyes estatales también protejan la confidencialidad de los expedientes del paciente.

B.37 Primary Care Case Management (PCCM) Community Health Services Referral Request Form

Provider Information		
Name:	Contact name:	Telephone:
Address:		
NPI:	TPI:	

Client Information		Client Information	
Name:		Name:	
Medicaid number:		Medicaid number:	
Telephone:		Telephone:	
Reason for Referral		Reason for Referral	
☐ Appointment no show	☐ Abuse of emergency room	☐ Appointment no show	☐ Abuse of emergency room
☐ Treatment plan adherence	☐ Abuse of doctor/staff	☐ Treatment plan adherence	☐ Abuse of doctor/staff
☐ Other:		☐ Other:	
Case Management/Health Education Needs		Case Management/Health Education Needs	
☐ Asthma	☐ Childhood illness	☐ Asthma	☐ Childhood illness
☐ Community resources	☐ Cardiac	☐ Community resources	☐ Cardiac
☐ Nutrition	☐ Transportation	☐ Nutrition	☐ Transportation
☐ Dental	☐ Parenting	☐ Dental	☐ Parenting
☐ Behavioral psych disorder	☐ Diabetes	☐ Behavioral psych disorder	☐ Diabetes
☐ Prenatal	☐ Exercise	☐ Prenatal	☐ Exercise
☐ Tobacco use		☐ Tobacco use	
☐ Child/Adult with Special Health Care Needs		☐ Child/Adult with Special Health Care Needs	
☐ Other:		☐ Other:	
Comments:		Comments:	

Client Information		Client Information	
Name:		Name:	
Medicaid number:		Medicaid number:	
Telephone:		Telephone:	
Reason for Referral		Reason for Referral	
☐ Appointment no show	☐ Abuse of emergency room	☐ Appointment no show	☐ Abuse of emergency room
☐ Treatment plan adherence	☐ Abuse of doctor/staff	☐ Treatment plan adherence	☐ Abuse of doctor/staff
☐ Other:		☐ Other:	
Case Management/Health Education Needs		Case Management/Health Education Needs	
☐ Asthma	☐ Childhood illness	☐ Asthma	☐ Childhood illness
☐ Community resources	☐ Cardiac	☐ Community resources	☐ Cardiac
☐ Nutrition	☐ Transportation	☐ Nutrition	☐ Transportation
☐ Dental	☐ Parenting	☐ Dental	☐ Parenting
☐ Behavioral psych disorder	☐ Diabetes	☐ Behavioral psych disorder	☐ Diabetes
☐ Prenatal	☐ Exercise	☐ Prenatal	☐ Exercise
☐ Tobacco use		☐ Tobacco use	
☐ Child/Adult with Special Health Care Needs		☐ Child/Adult with Special Health Care Needs	
☐ Other:		☐ Other:	
Comments:		Comments:	

For Primary Care Case Management Clients Only
Fax to Community Health Services at (512) 302-0318
Referrals are also received by telephone at 1-888-276-0702 (M-F, 8 a.m. to 5 p.m., CST)

Effective Date_01152008/Revised Date_08032007

B.38 Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form

This form is used to obtain prior authorization (PA) for elective inpatient admission/procedures and outpatient services, update an existing inpatient or outpatient authorization, and provide notification of emergency admissions.

Telephone number: 1-888-302-6167 (option 1 inpatient, option 2 outpatient)	Fax number: 1-512-302-5039

Please check the appropriate action you are requesting

Inpatient Services	Outpatient (OP) Services
☐ Notification (complete fields in Section 1 excluding clinical documentation)	☐ Prior authorization for outpatient services (complete Section 1)
☐ DRG or clinical update (complete Section 2)	☐ Update/change codes from original OP PA request (complete Section 2)
☐ Non Routine OB/NB (complete Section 1)	
☐ Prior Authorization of scheduled admission/procedure (complete Section 1)	

Client Information

PCN Number:	Name:	Date of Birth: / /

Facility Information

Name:			
Address:			
Telephone:		Fax number:	
TPI:	NPI:	Taxonomy:	Benefit Code:

Admitting/Performing Physician Information

Name:		Telephone:	
Address:		Fax number:	
TPI:	NPI:	Taxonomy:	Benefit Code:

Form completed by:	Date form completed: / /

Section 1

Service Type	☐ Outpatient Service(s)	☐ Emergent/Urgent Admit	☐ Scheduled Admission/ Procedure	☐ Admit Following Observation

Date of service: / /	Procedure code(s):
Primary diagnosis code:	
Secondary diagnosis codes:	

*DRG code:	Reference number:	Discharge date: / /

Clinical documentation supporting medical necessity for a scheduled admission/procedure, outpatient services or non-routine OB/NB:

Section 2 (Update information when necessary)

Primary diagnosis code:		
Secondary diagnosis codes:		
Date of service: / /	Procedure code(s):	*DRG code:

Clinical documentation to support medical necessity of DRG or procedure code change:

Only required for DRG admission

Effective Date_07302007/Revised Date_07302007

B.39 Primary Care Case Management (PCCM) Referral Form

Primary Care Provider Information	
Name:	
Contact name:	Telephone:
NPI:	TPI:

Client Information	
Name:	Date of birth: / /
Medicaid number:	Telephone:
Provider signature:	Referral date: / /

Referring Provider Information (If different from the primary care provider)	
Name:	
Contact name:	Telephone:
NPI:	TPI:

Consulting Provider/Facility	
Provider/Facility name:	Telephone:
Address:	
Appointment time and date: ___:___ / /	Medicaid number (if known):
Reason for referral:	

To the Consultant

This notice authorizes the following care: ☐ Evaluation only ☐ Evaluation and treatment

☐ Evaluation and single treatment ☐ As needed Number of treatments _____

Other (specify):

Initial consultations are for one visit only for evaluation and development of a treatment plan unless otherwise specified. All consultations require a written report (preferably typed and attached to this form) to the primary care provider and phone conferences as necessary to assure continuity of care. Referrals are valid for 30 days from the time of issue and it is the consulting provider's responsibility to verify eligibility prior to delivering services. Consulting providers may not authorize secondary referrals. All requests for additional services or visits to other providers must come through the primary care provider. All claims are subject to retrospective review for purposes of determining eligibility, benefit coverage, appropriateness, and medical necessity. Claims payment may be affected by review findings.

Consultant comments:	
Consultant signature:	Date / /

Please return findings and report to the primary care provider listed above.

Effective Date_01152008/Revised Date_08032007

B.40 Primary Care Case Management (PCCM) Pre-Contractual/Recredentialing Site and Medical Record Evaluation

Provider Information			
Name:	TPI:		NPI:
Address:		City:	Zip:
Telephone:		Date: / /	

Site Evaluation					
Site Criteria	**Meets Criteria**		**Condition of participation**		**Comments (include provider's comments regarding any criteria not met)**
	Yes	**No**	**N/A**	**COP**	
Office Appearance					
1. Appears clean	☐	☐		**COP**	
2. Clearly visible	☐	☐			
3. In good repair	☐	☐		**COP**	
4. Not odorous	☐	☐			
5. Adequate seating	☐	☐		**COP**	
6. Good visibility from reception area	☐	☐			
Office Space					
7. Rest rooms available	☐	☐		**COP**	
8. Rest rooms adequate	☐	☐		**COP**	
9. Rest room(s) wheelchair accessible	☐	☐	☐	**COP**	
10. Number of examination rooms adequate	☐	☐		**COP**	
11. Examination rooms well-equipped	☐	☐		**COP**	
Emergency Preparedness					
12. Emergency equipment available	☐	☐			
13. What types of equipment	☐	☐			
14. Staff knowledgeable of equipment	☐	☐	☐	**COP**	
15. Staff trained in CPR	☐	☐			
16. Emergency numbers posted	☐	☐			
Safety					
17. Smoke alarms	☐	☐		**COP**	
18. Fire extinguisher	☐	☐		**COP**	
19. Exit signs	☐	☐		**COP**	
20. Passageways clear	☐	☐		**COP**	
21. Proper disposal of biological and chemical waste	☐	☐		**COP**	
Handicapped Access					
22. Wheelchair ramp	☐	☐		**COP**	
23. Wide doors	☐	☐		**COP**	
24. Elevators (not applicable if single story)	☐	☐	☐	**COP**	
Staff					
25. Courteous	☐	☐		**COP**	
26. Answer phones promptly	☐	☐		**COP**	
27. Appear knowledgeable	☐	☐			
28. Neat/well groomed	☐	☐			
Medical Records					
29. Individual charts for each client	☐	☐		**COP**	
30. Stored in dedicated space	☐	☐		**COP**	
31. Personal/biographical data present	☐	☐		**COP**	
32. Provider identification and date	☐	☐		**COP**	
33. Handwriting legible	☐	☐		**COP**	
34. Allergies noted prominently	☐	☐		**COP**	
35. Health education/preventive services noted	☐	☐		**COP**	
36. Advance directives offered (adults)	☐	☐	☐		
37. Confidentiality maintained	☐	☐		**COP**	
Determination	☐	☐			**Reviewer:**
Addendum Limited English Proficiency Question: Are translation services available to clients with limited English language skills?	☐	☐			Offer telephone numbers for translation services if needed.

Effective Date_01152008/Revised Date_08022007

B.41 Physician's Examination Report

Client Name (Last, First, M)	Client No.	Date of Birth
Address (Street, City, State, ZIP Code)		

1. Date Of Examination*

2. Ear Examination:

a. Within Normal Limits ❑ Yes ❑ No

b. Cerumen Removed ❑ Yes ❑ No

c. Describe Ear Abnormalities:

3. Is more otolaryngological examination/treatment required to provide medical clearance for the fitting of a hearing aid? ❑ Yes ❑ No

If yes, refer this patient for consultation and completion of this form.

4. Are there any medical contradictions to hearing aid usage in either ear? ❑ Yes ❑ No

If yes, a hearing aid is medically prohibited in ❑ Right Ear ❑ Left Ear

5. Is the above-named individual a candidate for a hearing aid evaluation? ❑ Yes ❑ No

Signature* - Physician	Physician's Name (please type or print)	Medical Specialty
Address		Telephone No.

***NOTE PLEASE FURNISH THE PATIENT WITH THE SIGNED AND DATED ORIGINAL AND ONE COPY OF THIS FORM**

This form and supporting documentation must be maintained in the client's file.

A new Physician's Examination Report must be completed any time there is a change in the client's hearing or a new hearing aid is needed.

B.42 Physician's Medical Necessity Certification for Nonemergency Ambulance Transports (Texas Medicaid Program)

Request Date: _____/_____/ _____	Transport Date: _____/_____/ _____
Patient's Name:	Medicaid Number:
Transported From:	Transported To:
Physician's Printed Name:	Physician License #:

In order for ambulance services to be covered, they must be medically necessary and reasonable. Medical necessity is established when the patient's condition is clinically considered severely disabled and as such that transportation by any other means (including services provided through the Medicaid Medical Transportation Program or through that which is included in the rate for Long Term Care - Nursing Facilities) is contraindicated. A round-trip transport from the client's home to a scheduled medical appointment (e.g., an outpatient or freestanding dialysis or radiation facility) is covered when the client meets the definition of severely disabled.

The HHSC Medicaid Program has defined "severely disabled" as that client's physical condition limits mobility and requires the client to be bed-confined at all times, unable to sit unassisted at all times, or requires continuous life-support systems (including oxygen or IV infusion).

Please complete the questions below in order for the authorization to be evaluated under Medicaid coverage criteria.

1.)Is the patient severely disabled as defined by the above definition? ❑Yes ❑No
2.)If no, this client does not qualify for nonemergency ambulance transport.
3.)If yes, please check the appropriate medical condition listed below.

This patient:

- ❑ Requires continuous oxygen and monitoring by trained staff
- ❑ Requires airway monitoring or suction
- ❑ Requires restraints or sedation **(MUST BE EXPLAINED IN OTHER)**
- ❑ Comatose and requires trained monitoring
- ❑ Is actively seizure-prone and requires trained monitoring
- ❑ Had to remain immobile because of a fracture/possibility of a fracture that had not been set
- ❑ Patient is ventilator-dependent
- ❑ Contractures **(MUST BE EXPLAINED IN OTHER)**
- ❑ Has advanced decubitus ulcers and requires wound precautions **(MUST BE EXPLAINED IN OTHER)**
- ❑ Requires isolation precautions (VRE, MRSA, etc.) **(MUST BE EXPLAINED IN OTHER)**
- ❑ Patient requires continuous IV therapy
- ❑ Requires cardiac monitoring
- ❑ Is exhibiting signs of a decreased level of consciousness **(MUST BE EXPLAINED IN OTHER)**
- ❑ Total hip replacement requires hip precautions and cannot sit safely **(MUST BE EXPLAINED IN OTHER)**
- ❑ **Other** (explain)

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE AND ACCURATE AND SUPPORTED IN THE MEDICAL RECORD OF THE PATIENT. THE INFORMATION BEING UTILIZED ON THIS FORM IS BEING GATHERED TO ASSIST IN SEEKING REIMBURSEMENT FOR A NONEMERGENCY AMBULANCE TRANSPORT FROM THE MEDICAID PROGRAM. I UNDERSTAND THAT ANY INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION, WHICH LEADS TO INAPPROPRIATE PAYMENTS, ARE SUBJECT TO INVESTIGATIONS UNDER APPLICABLE FEDERAL AND STATE LAWS. * **THIS AUTHORIZATION WILL BE VALID FOR 180 DAYS FROM THE DATE OF ISSUANCE AND WILL CERTIFY THAT THE PATIENT REMAINS SEVERELY DISABLED FOR THAT PERIOD OF TIME.**

Signature of Attending or Patient's Personal Physician _____/_____/_____ Date Signed

Requesting Provider Information

Name:	Telephone:
Address:	
Fax number:	TPI:
NPI:	Taxonomy:

Effective Date_07302007/Revised Date_06012007

B.43 Private Pay Agreement

Private Pay Agreement

I understand _____is accepting me as a private pay patient for the period of
(Provider Name)
_____, and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Signed: _____

Date: _____

B.44 Provider Information Change Form Instructions

Signatures

- The provider's signature is required on the Provider Information Change Form for any and all changes requested for individual provider numbers.
- A signature by the authorized representative of a group or facility is acceptable for requested changes to group or facility provider numbers.

Address

- Performing providers (physicians performing services within a group) may *not* change accounting information.
- For Traditional Medicaid and the CSHCN Services Program, changes to the accounting or mailing address require a copy of the W-9 form.
- For Traditional Medicaid, a change in ZIP Code requires copy of the Medicare letter for Ambulatory Surgical Centers.

Tax Identification Number (TIN)

- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers *cannot* change the TIN.

Provider Demographic Information

An online provider lookup (OPL) is available, which allows users such as Medicaid clients and providers to view information about Medicaid-enrolled providers. To maintain the accuracy of your demographic information, please visit the OPL at www.tmhp.com. Please review the existing information and add or modify any specific practice limitations accordingly. This will allow clients more detailed information about your practice.

General:

- TMHP must have either the nine-digit Texas Provider Identifier (TPI), or the National Provider Identifier (NPI)/Atypical Provider Identifier (API), primary taxonomy code, physical address, and benefit code (if applicable) in order to process the change. Forms will be returned if this information is not indicated on the Provider Information Change Form.
- The W-9 form is required for *all* name and TIN changes.
- Mail or fax the completed form to:

  Texas Medicaid & Healthcare Partnership (TMHP)
  Provider Enrollment
  PO Box 200795
  Austin, TX 78720-0795
  Fax: 512-514-4214

B.45 Provider Information Change Form

Traditional Medicaid, Children with Special Health Care Needs (CSHCN) Services Program, and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

Check the box to indicate a PCCM Provider ☐	Date : / /
Nine-Digit Texas Provider Identifier (TPI):	Provider Name:
National Provider Identifier (NPI):	Primary Taxonomy Code:
Atypical Provider Identifier (API):	Benefit Code:

List any additional TPIs that use the same provider information:

TPI:	TPI:	TPI:
TPI:	TPI:	TPI:
TPI:	TPI:	TPI:

Physical Address—The physical address cannot be a PO Box. Ambulatory Surgical Centers enrolled with Traditional Medicaid who change their ZIP Code must submit a copy of the Medicare letter along with this form.

Street address City County State Zip Code

Telephone: ( )	Fax Number: ( )	Email:

Accounting/Mailing Address—All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

Street Address City State Zip Code

Telephone: ( )	Fax Number: ( )	Email:

Secondary Address

Street Address City State Zip Code

Telephone: ( )	Fax Number: ( )	Email:

Type of Change (check the appropriate box)

☐	Change of physical address, telephone, and/or fax number
☐	Change of billing/mailing address, telephone, and/or fax number
☐	Change/add secondary address, telephone, and/or fax number
☐	Change of provider status (e.g., termination from plan, moved out of area, specialist) *Explain in the Comments field*
☐	Other (e.g., panel closing, capacity changes, and age acceptance)

Comments:

Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Tax ID number:	Effective Date:

Exact name reported to the IRS for this Tax ID:

Provider Demographic Information—Note: This information can be updated on www.tmhp.com.

Languages spoken other than English:

Provider office hours by location:

Accepting new clients by program (check one): Accepting new clients ☐ Current clients only ☐ No ☐

Patient age range accepted by provider:	Additional services offered (check one): HIV ☐ High Risk OB ☐
Participation in the Woman's Health Program? Yes ☐ No ☐	Patient gender limitations: Female ☐ Male ☐ Both ☐

Signature and date are *required* or the form will *not* be processed.

Provider signature:	Date: / /

Mail or fax the completed form to: Texas Medicaid & Healthcare Partnership (TMHP)
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

Fax: 512-514-4214

Effective Date_12042007/Revised Date_12042007

B.46 Psychiatric Inpatient Initial Admission Request Form

12357-B Riata Trace Parkway, Suite 150
Austin, Texas 78727-6422

TMHP CCIP

Telephone: 1-800-213-8877
Fax: 1-512-514-4211

I. Identifying Information					
Medicaid Number:			Date: / /		
Client Name	Last:		First:		Middle Initial:
Date of birth: / /	Age:	Sex:	Date of admission: / /	Time:	
Facility Information					
Name:			Contact Person:		
Address:					
TPI:	NPI:		Taxonomy:		Benefit Code:
Commitment Type: *(If applicable)*	Effective Date: / /		County:	Judge:	
Referral source: ☐ Admitting MD ☐ MH Professional ☐ Other (list):					
Current living arrangements: ☐ With parent(s) ☐ Group/foster home ☐ Other (list):					

IIA. Primary symptom described in "specific observable behavior" that requires acute hospital care
(Include: precipitating events leading to admission)

IIB. Other relevant clinical information, including inability to benefit from less restrictive setting
(Attach additional pages or documents, as necessary)

IIC. Psychiatric medications (include total daily doses)	**IID. Present and past drug/alcohol usage:**	
	Name of chemical	Current use?

IIE. Past psychiatric treatment

1. Number of previous inpatient admissions: [ ] Dates of most recent inpatient stay: / / to / /
2. Previous ambulatory/outpatient treatment (provider or facility, frequency) – If none, why:

III. Current diagnosis (Axis I):

IV. Additional diagnosis (Axis I and Axis II):

V. Current functional assessment scores (DSM IV): GAF [ ]

VI. No. of hospital days requested: [ ] Dates: / / to / /

Projected discharge date (required): / /

VII. Aftercare plan:

Provider or Facility:

Frequency:

Signature (attending MD):	Date: / /
Print name:	Provider license number
Provider TPI:	Provider NPI:

Effective Date_07302007/Revised Date_07102007

B.47 Psychiatric Inpatient Extended Stay Request Form

12357-B Riata Trace Parkway, Suite 150
Austin, Texas 78727-6422

TMHP CCIP

Telephone: 1-800-213-8877
Fax: 1-512-514-4211

I. Identifying Information					
Medicaid Number:			Date: / /		
Client Name	Last:		First:		Middle Initial:
Date of birth: / /		Age:	Sex:	Date of admission: / /	
Facility Information					
Name:			Contact Person:		
Address:					
TPI:	NPI:		Taxonomy:		Benefit Code:
Commitment Type: *(If applicable)*	Effective Date: / /		County:	Judge:	

IIA. Current status of primary symptoms that require continued acute hospital care
(Include: 1. Date of most recent occurrence; 2. Frequency; 3. Duration; 4. Severity)

IIB. Other relevant clinical/diagnostic information about the patient from the past 72 hours
(Attach additional pages or documents, as necessary)

IIC. Current psychiatric medication (include total daily doses)	**IID. Discharge criteria**
	1.
	2.
	3.

IIE. Describe treatment, contacts, plans (including outcome) with family, school, etc.

III. Current diagnosis (Axis I):

IV. Additional diagnosis (Axis I and Axis II):

V. Current functional assessment scores (DSM IV): GAF [ ]

VI. No. of hospital days requested: [ ] Dates: / / to / /

Projected discharge date (required): / /

VII. Aftercare plan:

Provider or Facility:

Frequency:

Signature (attending MD):	Date: / /
Print name:	Provider license number
Provider TPI:	Provider NPI:

Effective Date_07302007/Revised Date_07102007

B

B.48 Pulse Oximeter Form

Client Name:	Medicaid number:	
DME Provider Information		
Name:	Telephone:	Fax number:
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	

Equipment Information		
HCPCS Code	Product Name and Model Number	Retail Price
New device provided for purchase? ☐ Yes ☐ No		

Equipment designated for clinical use only is not considered appropriate for use in the home

Note: *Oxygen dependent is defined as ongoing, regular need for use of supplemental oxygen for a significant portion of the day to maintain oxygen saturation. This does not include: PRN use; when only used when sick; when only used when suctioning; when desaturation occurs only when crying; when desaturation occurs only with seizure activity.*

The following information must be completed by the physician

Diagnosis and Basis for Medical Necessity of requested services:						
Dates of Service requested for Prior Authorization		From: / /		To: / /		
☐	Client is ventilator and/or oxygen dependent					
	Client is ventilator dependent		hours per day	Client is oxygen dependent		hours per day
☐	Client is weaning from oxygen and/or a ventilator					
☐	Anticipated length of monitor need:	☐ Months:		☐ 1-3 years		☐ More than 3 years
☐	Who will respond to the monitor alarm?					
☐	Can the patient's medical needs be met with intermittent "spot check" of oxygen saturations?					☐ Yes ☐ No
☐	What is the medical basis for need of continuous monitoring?					
☐	Is the client receiving any nursing services such as PDN, Home Health Visits, MDCP, CBA, and Private Insurance?					
	Please indicate services:					
	Number of hours/visits:					

Physician Information		
Signature:		Date: / /
Name (printed):	Telephone:	
Address:		
TPI:	NPI:	License number:

Must be submitted with a THSteps-CCP Prior Authorization Request Form

Effective Date_07302007/Revised Date_06012007

B.49 Radiology Prior Authorization Request Form

This form is used to obtain prior authorization (PA) for elective outpatient services or update an existing outpatient authorization.

Telephone number: 1-800-572-2116		Fax number: 1-800-572-2119		Date of Request: / /
Please check the appropriate action requested:				
☐ CT Scan	☐ CTA Scan	☐ MRI Scan	☐ MRA Scan	☐ Update/change codes from original PA request
Client Information				
Name:		Medicaid number:		Date of Birth: / /
Facility Information				
Name:				Reference number:
Address:				
TPI:			NPI:	
Taxonomy:			Benefit Code:	
Requesting/Referring Physician Information				
Name:				License number:
Address:				
Telephone:			Fax number:	
TPI:			NPI:	
Taxonomy:			Benefit Code:	
Section 1				
Service Types	Outpatient Service(s) ☐		Emergent/Urgent Procedure ☐	
Date of Service: / /			Procedures Requested:	
Diagnosis Codes	Primary:		Secondary:	
Clinical documentation supporting medical necessity for a radiology procedure includes treatment history, treatment plan, medications, and previous imaging results:				
Requesting/Referring Physician (Signature Required):				
Print Name:			Date: / /	
Section 2— Updated Information (when necessary)				
Date of Service: / /			Procedures Requested:	
Diagnosis Codes	Primary:		Secondary:	
Clinical documentation supporting medical necessity for a procedure code change includes treatment history, treatment plan, medications, and previous imaging results:				
Requesting/Referring Physician (signature required):				
Print Name:			Date: / /	
Physician must complete and sign this form prior to requesting authorization.			Requesting/Referring Physician License No.:	
Requesting/Referring Physician NPI:			Requesting/Referring Physician TPI:	

Effective Date_07302007/Revised Date_08062007

B

B.50 Request for Initial Outpatient Therapy (Form TP-1)

Request For Initial Outpatient Therapy (Form TP-1)

CCP - Texas Medicaid & Healthcare Partnership PO Box 200735 Austin TX 78720-0735 1-800-846-7470 CCP FAX: 1-512-514-4212	Texas Medicaid & Healthcare Partnership CSHCN PO Box 200855 Austin TX 78720-0855 1-800-568-2413 or 1-512-514-3000 FAX: 1-512-514-4222

Medicaid Number:		CSHCN Number:	
Client Name:	Date of birth: / /	Telephone:	
Client Address:			
Has the child received therapy in the last year from the public school system? ☐ Yes ☐ No			
Date of Initial Evaluation	PT	OT	SLP
A copy of the initial evaluation must be attached			
ICD-9 Code/Diagnosis:		Date of onset:	

Category of Therapy Being Requested

PT/OT for:	☐ Developmental anomalies	☐ Pre-surgery	☐ Post-surgery Date of surgery / /	
☐ Cast Removal Date Removed / /		☐ Serial Casting	☐ Acute Episode of Chronic Condition	
☐ New Condition	☐ Specialty Clinic	☐ Home Program	☐ ADL (activities of daily living)	
☐ Equipment Assessment		☐ Equipment Training		
Speech for:	☐ Craniofacial	☐ Developmental Anomalies	☐ New Condition	☐ Post Cochlear Implant

Check the service requested, indicate the date(s) of service and frequency per week or month:
Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

Service Type	Service Date(s)		Frequency per week	Frequency per month
	From:	To:		
☐ **PT**	/ /	/ /		
☐ **OT**	/ /	/ /		
☐ **SLP**	/ /	/ /		

Procedure code(s) for therapy services:

Specialist	Name	Signature	Date Signed
Physician			/ /
PT Therapist			/ /
OT Therapist			/ /
SLP Therapist			/ /

Provider Information

Name:	Telephone:	Fax:
Address:		

Medicaid Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

CSHCN Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

FOR OFFICE USE ONLY: Medicaid ☐ Yes ☐ No HMO ☐ Yes ☐ No Restrictions:

PAN# Valid To

FORM TP-1

Effective Date_07302007/Revised Date_06012007

B.51 Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)

Request for Extension of Outpatient Therapy (Form TP-2)

CCP - Texas Medicaid & Healthcare Partnership PO Box 200735 Austin TX 78720-0735 1-800-846-7470 CCP FAX: 1-512-514-4212	Texas Medicaid & Healthcare Partnership CSHCN PO Box 200855 Austin TX 78720-0855 1-800-568-2413 or 1-512-514-3000 FAX: 1-512-514-4222

Medicaid Number:		CSHCN Number:	
Client Name:		Date of birth: / /	Telephone:
Client Address:			
Has the child received therapy in the last year from the public school system? ☐ Yes ☐ No			
Date of Initial Evaluation	PT	OT	SLP

A copy of the initial evaluation must be attached

ICD-9 Code/Diagnosis:	Date of onset:

Category of Therapy Being Requested

PT/OT for:	☐ Developmental anomalies	☐ Pre-surgery	☐ Post-surgery Date of surgery / /	
☐ Cast Removal Date Removed / /		☐ Serial Casting	☐ Acute Episode of Chronic Condition	
☐ New Condition	☐ Specialty Clinic	☐ Home Program	☐ ADL (activities of daily living)	
☐ Equipment Assessment		☐ Equipment Training		
Speech for:	☐ Craniofacial	☐ Developmental Anomalies	☐ New Condition	☐ Post Cochlear Implant

Check the service requested, indicate the date(s) of service and frequency per week or month:
Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

Service Type	Service Date(s)		Frequency per week	Frequency per month
	From:	To:		
☐ **PT**	/ /	/ /		
☐ **OT**	/ /	/ /		
☐ **SLP**	/ /	/ /		

Procedure code(s) for therapy services:

Specialist	Name	Signature	Date Signed
Physician			/ /
PT Therapist			/ /
OT Therapist			/ /
SLP Therapist			/ /

Provider Information

Name:	Telephone:	Fax:
Address:		

Medicaid Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

CSHCN Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

FOR OFFICE USE ONLY: Medicaid ☐ Yes ☐ No HMO ☐ Yes ☐ No Restrictions:

FORM TP-2 Page 1 of 2

Effective Date_07302007/Revised Date_06012007

B

PAN# Valid To

Medicaid Number:	CSHCN Number:
Client Name:	Date of birth: / /

Current Functional Status:

New Treatment Goals:

Prior Dates of Service: from / / to / /

Prior Functional Status:

Prior Treatment Goals:

Prior Treatment Provided:

FORM TP-2 Page 2 of 2

Effective Date_07302007/Revised Date_06012007

B.52 Request for Extended Outpatient Psychotherapy/Counseling Form

1. Identifying Information					
Client Information					
Medicaid number:			Date: / /		
Client name	Last:		First:		Middle Initial:
Date of birth: / /	Age:	Sex:	Began current treatment: / /		
Current living arrangements:	☐ With parent(s)	☐ Group/foster home	☐ Other (list):		
Provider Information					
Performing provider:			Telephone:		
Address:					
TPI:			NPI:		
Taxonomy:			Benefit Code:		
2. Current DSM IV diagnosis (list all appropriate codes):					
Axis I diagnosis:					
Axis II diagnosis:			GAF:		
Current substance abuse?	☐ None	☐ Alcohol	☐ Drugs	☐ Alcohol and Drugs	
3. Recent primary symptoms that require additional therapy/counseling					
Include date of most recent occurrence, frequency, duration, and severity:					
4. History					
Psychiatric inpatient treatment	☐ Yes	☐ No	Age at first admission:		
Prior substance abuse?	☐ None	☐ Alcohol	☐ Drugs	☐ Alcohol and Drugs	
Significant medical disorders:					
5. Current psychiatric medications (include dose and frequency):					
6. Treatment plan for extension					
Measurable short term goals, specific therapeutic interventions utilized and measurable expected outcome(s) of therapy:					
7. Number of additional sessions requested (limit 10 per request)					
List the specific procedure codes requested:					
How many of each type?	IND		Group		Family
Dates	From (start of extension visits): / /		To (end of planned requested visits): / /		
List specific procedure codes requested:					
Provider signature:				Date: / /	
Provider printed name:					

Effective Date_07302007/Revised Date_06012007

B

B.53 Sample Letter - XUB Computer Billing Service Inc.

XUB Computer Billing Service, Inc.
4040 Main Street
Anytown, USA 11111

Dear Sir:

This letter authorizes the XUB Computer Billing Service, Inc. to use my signature and to attest on my behalf to the requirements authorized in the following paragraphs, when submitting Medicaid claims on my behalf.

This is also to certify that information appearing on billings submitted by me for the Texas Medical Assistance Program is and will be true, accurate, and complete. I understand that payment of any Texas Medical Assistance Program claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. These certifications are made in accordance with requirements found at 42 Code Federal Regulations 455.18 and 455.19.

I also certify that the items billed to the Texas Medical Assistance Program are and will be for services that have been and will be personally provided by me or under my personal direction, and in cases of physician services, the services, supplies, or other items billed have been and will be medically necessary for the diagnosis or treatment of the condition of the patients, and are provided without regard to race, color, sex, national origin, age, or handicap.

Additionally, I agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the Texas Medical Assistance Program. I also agree to furnish them at no cost and provide access to information regarding any payments claimed for providing such services as the State Agency, Attorney General's Office, and Department of Health and Human Services (HHS) Office may request for five years from date of service (6 years for freestanding rural health clinic; 10 years for hospital-based rural health clinic), or until any dispute is settled, whichever occurs first.

I agree to accept the amounts paid by the Medicaid Program as full payment for the services rendered for which a Medicaid benefit is provided under the Texas Medical Assistance Program.

This letter, to be retained in your files, bears my true and original signature:

_____/_____/_____
Provider Signature Date

_____ _____
TPI NPI

B.54 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen, Instructions

Note: *Form G-1C, Maternal Serum Prenatal Triple Screen, is provided for the provider's convenience. Previously it was part of the G-1B form. It is not a THSteps form.*

For information on Triple Screens, call: 1-800-687-4363 or 1-888-963-7111 x7138 or Fax: (512) 458-7139.
For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.state.tx.us/lab/.

The specimen submission form ***must*** accompany each specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
If the Date of Collection field is not completed, the specimen will be rejected.

Place Bar Code Label Here: Place the specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system. If you are performing remote entry, place specimen bar code label here.

Section 1. SUBMITTER INFORMATION

All submitter information is required.

Submitter/TPI number, Submitter name and Address: The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. For Texas Health Steps (THSteps) specimens, use the pre-assigned Texas Provider Identifier (TPI) number. To obtain a TPI number and THSteps enrollment, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 458-7578, or fax (512) 458-7533.

NPI Number: Beginning May 23, 2007, all health care providers must use the National Provider Identifier (NPI) number and the TPI number or other submitter number will no longer be used. The NPI number is the new national standard identifier for health care providers adopted by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Laboratory Services Section.

Contact Information: Indicate the telephone number and name of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen. The fax number should indicate the number of the fax machine where the report should be sent.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including last name, first name, middle initial, address, city, state, zip code, telephone number, country of origin, race/ethnicity, date of birth, age, sex, social security number (SSN), pregnant, medical record number, ICD diagnosis code, and previous DSHS lab specimen number.

NOTE: The patient's name listed on the specimen ***must*** match the patient's name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). You may use a pre-printed patient label.

ICD Diagnosis Code: Indicate the diagnosis code that would help in processing, identifying, and billing of this specimen.

Section 3. TRIPLE SCREEN REQUEST & PATIENT INFORMATION

In order to interpret this test, **all** patient information in this section of this form must be provided. Without the date of collection, accurate gestational age, maternal weight, maternal date of birth, maternal race, and information about maternal diabetic status, a complete assessment cannot be made. *The time and date the specimen is removed from freezer* ***must*** *be provided to determine specimen acceptability.*

Section 4. PHYSICIAN INFORMATION

Physician's name, UPIN, and NPI Number: Give the name of the physician and their unique physician ID number (UPIN) and NPI number, if applicable. Beginning May 23, 2007, the NPI number will replace the UPIN. This information is required to bill Medicare and insurance.

Section 5. PAYOR SOURCE

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided or multiple boxes are checked**.**

Indicate the party that will receive the bill.

Medicaid or Medicare:
- Mark the appropriate box and write in the Medicaid or Medicare number.
- If the patient name on the form does not match the name on the card, the submitter will be billed.

Private Insurance:
- Mark the appropriate box, and
- Complete all fields on the form that have an asterisk (*).
- If the private insurance information is not provided on the specimen form, the submitter will be billed.

DSHS Program:
- Do NOT check a DSHS program as a Payor Source if the patient has Medicaid or Medicare.
- If you are contracting and/or enrolled with a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section's Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/.
- If there is no other Payor Source for the patient and the patient meets the program's eligibility criteria, check the appropriate DSHS program.

HMO / Managed care / Insurance company: Print the name, address, city, state, and zip code of the insurance company to be billed. If all insurance information is not provided on the specimen form, the submitter will be billed.

Responsible party: Print the name of the responsible party, the insurance ID number, insurance company's phone number, group name, and group number.

Signature and Date: Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

For specific test instructions and information about tube types, see the Laboratory Services Section Manual of Reference Services on our web site at http://www.dshs.state.tx.us/lab/.

B.55 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen

Note: *Form G-1C, Maternal Serum Prenatal Triple Screen, is provided for the provider's convenience. Previously it was part of the G-1B form. It is not a THSteps form.*

TEXAS Department of State Health Services

Prenatal Screening: (800) 687-4363

G-1C Specimen Submission Form (MAR 2006) Rev 2
CLIA #45D0660644

Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111 x7318 or (512) 458-7318
http://www.dshs.state.tx.us/lab

Place Bar Code Label Here

Section 1. SUBMITTER INFORMATION – (REQUIRED)**

Submitter/TPI Number **
Submitter Name **
NPI Number **
Address
City **
State **
Zip Code **
Phone **
Contact
Fax
Clinic Code

Section 2. PATIENT INFORMATION -- (REQUIRED)**

NOTE: **Patient name** on specimen is **REQUIRED & MUST** match name on this form & Medicare/Medicaid card.

Last Name **
First Name **
MI
Address **
Telephone Number
City **
State **
Zip Code **
Country of Origin

Race: ☐ White / Caucasian ☐ American Indian / Native Alaskan ☐ Native Hawaiian / Pacific Islander ☐ Black or African American ☐ Asian ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Semitic ☐ Chinese ☐ Filipino ☐ Korean ☐ Oriental ☐ Multiple ☐ Not Specified ☐ Unknown

DOB (mm/dd/yyyy) **
Age
Sex
SSN **
Pregnant? ☐ Yes ☐ No ☐ Unknown
Medical Record Number
ICD Diagnosis Code **
Previous DSHS Specimen Lab Number

Section 3. TRIPLE SCREEN REQUEST & PATIENT INFORMATION

NOTES: Please see the form's instructions for details on how to complete this form. Details of test and specimen requirements can be found in the Laboratory Services Section's Manual of Reference Services. Visit our web site at http://www.dshs.state.tx.us/lab/.

(All information is required for testing.)

O.B. History G_____ P_____ AB_____

	Yes	No	
Multiple fetuses?	☐	☐	Specify *number of fetuses:* _____
On insulin **prior to** pregnancy (IDDM)	☐	☐	
Maternal medication	☐	☐	Specify: _____
Repeat specimen?	☐	☐	If yes, indicate reason: _____

Gestational Age (Select one calculation method.)

☐ DATE of LMP _____ (mm/dd/yy)
☐ Ultrasound dating _____ weeks _____ days on _____ (mm/dd/yy)
☐ If sono by 1/10 of week _____.____ weeks on _____ (mm/dd/yy)
☐ Physical exam _____ weeks _____ days on _____ (mm/dd/yy)
☐ Estimated Delivery Date _____ (mm/dd/yy) by: US_____ LMP_____ Exam____

CURRENT WEIGHT	DATE OF COLLECTION	TIME OF COLLECTION	COLLECTED BY	Time and Date of Removal from Freezer prior to shipping (REQUIRED)

Section 4. PHYSICIAN INFORMATION -- (REQUIRED)**

Physician's Name **
Physician's UPIN **
Physician's NPI Number **

Section 5. PAYOR SOURCE – (REQUIRED)

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. If private insurance or DSHS Program is indicated, the required billing information below is designated with an asterisk (*). If required information is not provided, **THE SUBMITTER WILL BE BILLED.**

☐ Submitter ☐ Private Insurance
☐ Medicaid ☐ Medicare

Medicaid/Medicare #: _____
(attach copy of card)

DSHS Programs:
☐ Title V – Family Planning ☐ Other: _____
☐ Title V – MCH
☐ Title X – Family Planning
☐ Title XX – Family Planning

HMO / Managed Care / Insurance Company Name *
Address *
City *
State *
Zip Code *
Insurance Phone Number *
Responsible Party's Insurance ID Number *
Group Name *
Group Number *

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section." Signature of patient or responsible party.

Signature * Date *

FOR DSHS LABORATORY USE ONLY

Specimen received
Specimen condition
Verify specimen
Edit
Completed
Mailed & faxed
Revised, mailed & faxed
Revised, mailed & faxed

B.56 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen, Spanish Instructions (2 Pages)

Marzo de 2006 Página 1 de 2

Instrucciones del formulario de remisión de muestras de pruebas triples prenatales de suero materno G-1C

Puede obtener información sobre las Pruebas triples llamando al: 1-800-687-4363 ó 1-888-963-7111, extensión 7138, o mandando un fax al: (512) 458-7139.
Para obtener información sobre envíos por correo y el embalaje de las muestras, visite la página web de la Sección de Servicios de Laboratorio del DSHS en http://www.dshs.state.tx.us/lab/.

Debe acompañar cada muestra con un formulario de remisión de muestras.
El nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.
Si no rellena el campo Fecha de obtención, se rechazará la muestra.

Coloque la etiqueta de código de barra aquí: coloque la etiqueta de código de barra de la muestra a ser usada para identificar y ubicar la muestra en el sistema de administración de datos del laboratorio del DSHS. Si está ingresando remotamente, coloque la etiqueta de código de barra de la muestra aquí.

Sección 1. DATOS DEL REMITENTE

Se requieren todos los datos del remitente.

Número de remitente y de TPI, nombre y dirección del remitente: el número de remitente es un número único que la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas (Texas Department of State Health Services [DSHS]) asigna a cada uno de nuestros remitentes. Para muestras de Pasos Sanos de Texas (Texas Health Steps [THSteps]), utilice el número Identificador de proveedor de Texas (Texas Provider Identifier [TPI]) preasignado. Para obtener un número de TPI e inscribirse en Pasos Sanos de Texas, llame a la Asociación de Medicaid y Salud de Texas (Texas and Healthcare Partnership [TMHP]) al 1-800-925-9126.

Para solicitar un número de remitente a la Sección de Servicios de Laboratorio del DSHS, el formulario original o para cambiar los datos del remitente, sírvase llamar al (888) 963-7111, extensión 7578, o al (512) 458-7578 o mandar un fax al (512) 458-7533.

Núm. de NPI: a partir del 23 de mayo de 2007, todos los proveedores de salud deben usar el número Identificador de proveedor nacional (National Provider Identifier [NPI]) y ya no se usará el número de TPI u otro número de remitente. El número NPI es el nuevo identificador nacional oficial para proveedores de salud adoptado por los Centros de Servicios de Medicaid y Medicare (Centers for Medicare & Medicaid Services [CMS]) de conformidad con la Ley de Transferibilidad y Responsabilidad de Seguros Médicos (Health Insurance Portability and Accountability Act [HIPAA]) de 1996. Para obtener un número de NPI, llame al Sistema Nacional de Enumeración de Planes y Proveedores (National Plan and Provider Enumeration System [NPPES]) gratis al (800) 465-3203 o visite su sitio web en https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indique el nombre, dirección, ciudad, estado y código postal del remitente. Escriba claramente en letra de molde, utilice una etiqueta preimpresa o utilice una fotocopia del formulario original proporcionado por la Sección de Servicios de Laboratorio.

Datos de contacto: indique el número telefónico y el nombre de la persona a contactar en el centro remitente en caso de que el laboratorio necesite información adicional sobre la muestra. El número de fax debe indicar el número de la máquina de fax adónde se debe enviar el informe.

Código de la clínica: sírvase proporcionarlo, de ser aplicable. Se trata de un código que el remitente provee para ayudar a identificar cuál oficina satélite remite una muestra y para ayudar al remitente a identificar adónde pertenece el informe de laboratorio, si el remitente tuviese una dirección de correo postal primaria con oficinas satélite.

Sección 2. DATOS DEL PACIENTE

Rellene todos los datos del paciente incluido el apellido, el nombre, la inicial del segundo nombre, la dirección, ciudad, estado, código postal, número telefónico, país de origen, raza/etnia, fecha de nacimiento, edad, sexo, número de Seguro Social, si es mujer si está embarazada, número de expediente médico, código diagnóstico de ICD y número previo del laboratorio de muestras del DSHS.

NOTA: el nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.

La información requerida para facturar a Medicare, Medicaid o un seguro privado ha sido señalada con doble asterisco (**). Puede utilizar una etiqueta de paciente preimpresa.

Código diagnóstico de ICD: indique el código diagnóstico que ayudaría a procesar, identificar y facturar la muestra.

Sección 3. SOLICITUD DE PRUEBA TRIPLE Y DATOS DEL PACIENTE

A fin de interpretar la prueba, se deben proporcionar **todos** los datos del paciente en esta sección del formulario. Sin la fecha de obtención, la edad de gestación precisa, el peso materno, la fecha de parto, la raza materna y la información sobre el estado diabético materno, no se puede realizar una evaluación completa. *Se **debe** proporcionar la fecha y hora de remoción de la muestra del congelador para determinar la aceptabilidad de la muestra.*

Sección 4. DATOS DEL MÉDICO

Nombre y número de UPIN y NPI del médico: dé el nombre del médico y el número identificador único del médico (unique physician ID number [UPIN]) y el número NPI, de ser aplicable. A partir del 23 de mayo de 2007, el número NPI reemplazará al UPIN. Se requiere esa información para facturar a Medicare y al seguro.

Sección 5. PAGADOR

SE FACTURARÁ AL REMITENTE, si no se proporciona la información de facturación requerida o si se marcan múltiples casillas**.**

Indique la parte que recibirá la factura.

Medicaid o Medicare:
- Marque la casilla correspondiente y escriba el número de Medicaid o Medicare.
- Si el nombre del paciente del formulario no es el mismo que el nombre de la tarjeta, se facturará al remitente.

Seguro privado:
- Marque la casilla correspondiente y
- Rellene todos los campos del formulario que tengan asterisco (*).
- Si no proporciona los datos del seguro privado en el formulario de la muestra, se facturará al remitente.

Programa del DSHS:
- NO marque un programa del DSHS como Pagador si el paciente cuenta con Medicaid o Medicare.
- Si está contratado o inscrito en un programa del DSHS para proporcionar servicios que requieran pruebas de laboratorio, sírvase indicar qué programa es. Encontrará las descripciones de los programas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en el sitio web http://www.dshs.state.tx.us/lab/.
- Si no existe otro Pagador del paciente y el paciente reúne los criterios de participación del programa , marque el programa del DSHS correspondiente.

HMO/Atención dirigida/aseguradora: ponga en letra de molde el nombre, dirección, ciudad, estado y código postal de la aseguradora a la que se facturará. Si no proporciona todos los datos del seguro en el formulario de la muestra, se facturará al remitente.

Parte responsable: ponga en letra de molde el nombre de la parte responsable, el número de identificación del seguro, el número telefónico de la aseguradora, el nombre del grupo y el número del grupo.

Firma y fecha: haga que la parte responsable firme y feche para autorizar la divulgación de los datos de la misma, si DSHS ha de facturar al seguro o HMO de ésta.

Puede encontrar instrucciones de pruebas e información específica sobre los tipos de probetas de ensayo en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en nuestro sitio web en http://www.dshs.state.tx.us/lab/.

B.57 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen (Spanish, 2 Pages)

TEXAS Department of State Health Services

Prueba prenatal: (800) 687-4363

G-1C Formulario de remisión de muestras (MZO. 2006) Rev. 2

CLIA núm. 45D0660644

Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111, ext. 7318, o (512) 458-7318
http://www.dshs.state.tx.us/lab

Coloque la etiqueta de código de barra aquí

Sección 1. DATOS DEL REMITENTE – (REQUERIDO)**

Núm. de remitente y de TPI **

Nombre del remitente **

Núm. de NPI **

Dirección

Ciudad **

Estado **

Código Postal **

Núm. de teléfono **

Contacto

Fax

Código de la clínica

Sección 2. DATOS DEL PACIENTE -- (REQUERIDO)**

NOTA: se **REQUIERE** el **nombre del paciente** en la muestra **y** éste **DEBE** ser el mismo que el nombre del formulario y la tarjeta de Medicare/Medicaid.

Apellido **

Primer nombre **

Inicial del 2.º nombre

Dirección **

Núm. de teléfono

Ciudad **

Estado **

Código Postal **

País de origen

Raza: ☐ Blanca/caucásica ☐ Negra o afroamericana ☐ Amerindia/nativa de Alaska ☐ Asiática ☐ Nativa de Hawai/isleña del Pacífico ☐ Otra

Etnia: ☐ Hispana ☐ No hispana ☐ Filipina ☐ Coreana ☐ Semítica ☐ China ☐ Oriental ☐ Múltiple ☐ No se especifica ☐ Se desconoce

Fecha de nacimiento (mm/dd/aaaa) **

Edad

Sexo

Núm. de Seguro Social **

Si es mujer, ¿está embarazada? ☐ Sí ☐ No ☐ Se desconoce

Núm. de expediente médico

Código diagnóstico de ICD **

Núm. previo de laboratorio de muestras del DSHS

Sección 3. SOLICITUD DE PRUEBA TRIPLE Y DATOS DEL PACIENTE

NOTAS: consulte las instrucciones del formulario para conocer los detalles de cómo rellenarlo. Puede encontrar los detalles de los requisitos de pruebas y muestras en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio. Visite nuestro sitio web en http://www.dshs.state.tx.us/lab/.

(Se requiere toda la información para las pruebas).

Historial de obstetricia G_____ P_____ AB_____

	Sí	No	
¿Fetos múltiples?	☐	☐	Especifique *el número de fetos:* _____
Uso de insulina **previo al** embarazo (IDDM)	☐	☐	
Medicamento materno	☐	☐	Especifique: _____
¿Repetir muestra?	☐	☐	Si "sí", indique la razón: _____

Edad de gestación (elija un método de cálculo).

Sección 4. DATOS DEL MÉDICO -- (REQUERIDO)**

Nombre del médico **

UPIN del médico **

Núm. NPI del médico **

Sección 5. PAGADOR – (REQUERIDO)

Indique si debemos facturar al remitente, a Medicaid, a Medicare, al seguro privado o al programa del DSHS. Si indica Medicaid o Medicare, se requiere el número de Medicaid/Medicare. Si indica seguro privado o programa del DSHS, la siguiente información de facturación requerida se señala con un asterisco (*).
Si no provee la información requerida,
SE FACTURARÁ AL REMITENTE.

☐ Remitente ☐ Seguro privado
☐ Medicaid ☐ Medicare

Núm. de Medicaid/Medicare: _____
(anexe la copia de la tarjeta)

Programas del DSHS:

☐ Título V – Planificación familiar ☐ Otro: _____
☐ Título V – MCH
☐ Título X – Planificación familiar
☐ Título XX – Planificación familiar

Nombre de la HMO/Atención dirigida/aseguradora *

Dirección *

Ciudad *

Estado *

Código Postal *

Núm. tel. de aseguradora *

Núm. de id. de seguro de parte responsable *

Nombre del grupo *

Núm. del grupo *

"Por este conducto autorizo la divulgación de información relativa a los servicios aquí descritos y asimismo asigno toda prestación a la que tenga derecho a la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas".
Firma del paciente o la parte responsable.

Firma *

Fecha *

FOR DSHS LABORATORY USE ONLY

Specimen received

Specimen condition

Verify specimen

Edit

B

☐ FECHA de LMP _____ (mm/dd/aa)

☐ Datación de ultrasonido _____ semanas _____ días el _____ (mm/dd/aa)

☐ Si es ecografía a 1/10 de semana _____.____ semanas el _____ (mm/dd/aa)

☐ Examen físico _____ semanas _____ días el _____ (mm/dd/aa)

☐ Fecha de parto calculada _____ (mm/dd/aa) por: US_____LMP_____ Examen____

PESO ACTUAL	FECHA DE OBTENCIÓN	HORA DE OBTENCIÓN	OBTENIDA POR	Fecha y hora de remoción del Congelador antes del envío (REQUERIDO)

Completed

Mailed & faxed

Revised, mailed & faxed

Revised, mailed & faxed

B.58 Statement for Initial Wound Therapy System In-Home Use (2 Pages)

Statement for Initial Wound Therapy System In-Home Use (Page 1 of 2)

Patient Name:	Patient Medicaid Number:
Patient Diagnosis:	Date of birth: / /

Home Health Agency Information

Name:	Telephone:
Address:	
TPI:	NPI:
Taxonomy:	Benefit Code:

Indicators for Continuation of Treatment

Must be completed by the physician familiar with the client and prescribing the wound care system. Answer "Yes" or "No" for each question and any answers which apply.

1. Was the initial medical necessity justified by one of the following? **Yes** ☐ **No** ☐

- ☐ Stage III or Stage IV pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

2. The patient's history reflects one or more of the following: **Yes** ☐ **No** ☐

- ☐ Previous failed wound care interventions, how long ago_____, how was it resolved_____
- ☐ Severe coexisting chronic illness
- ☐ Frequent reoccurrence of advanced pressure ulcers related to severely limited mobility
- ☐ Wound care therapy was initiated in the hospital or skilled nursing facility (SNF). If "Yes," provide the following:

Admission date: / /	Admitting diagnosis:	Discharge date: / /

3. The patient uses a pressure-reducing surface: **Yes** ☐ **No** ☐

- ☐ Non-powered mattress overlay
- ☐ Non-powered mattress replacement
- ☐ Powered mattress overlay
- ☐ Powered mattress replacements
- ☐ Powered bed system
- ☐ Air fluidized bed

NOTE: If "No," why not?

4. The patient has an albumin greater than 3 mg/dl. **Yes** ☐ **No** ☐

Date of last albumin (within the past 30 days): / / Result:

NOTE: If the patient has an albumin level less than 3 mg/dl, please list the albumin level and describe the type of nutritional treatment which the patient is receiving:

5. The patient has diabetes mellitus. **Yes** ☐ **No** ☐

Hemoglobin A1c level:	Date Hemoglobin A1c drawn (within the past 30 days): / /

6. The patient's wound is free of necrotic tissue. **Yes** ☐ **No** ☐

NOTE: If the wound has recently been debrided, identify the type and date of debridement:

- ☐ Surgical Date: / / ☐ Physical Date: / /
- ☐ Chemical Date: / / ☐ Autolytic Date: / /

7. The patient's wound is free of infection. **Yes** ☐ **No** ☐

NOTE: If the wound is infected, identify the wound treatment, include dosage, frequency, route and duration of any medications (including, but not limited to, antibiotics):

8. The patient's overall health status will allow wound healing. **Yes** ☐ **No** ☐

NOTE: Describe all medical conditions which might affect wound healing, address incontinence if pertinent, and what is being done to decrease contamination of the wound:

9. Name of family member/friend/caregiver who agrees to be available to assist patient:

Physician Information

Signature:		Date: / /
Name (print):	Telephone:	
License number:	TPI:	NPI:

Effective Date_07302007/Revised Date_06012007

B

Statement for Initial Wound Therapy System In-Home Use (Page 2 of 2)

Patient Name:	Patient Medicaid Number:
Patient Diagnosis:	Date of birth: / /

Contraindicators to Initial Wound Therapy

Must be completed by the physician familiar with the client and subscribing the wound care system or the registered nurse (RN). Check any that apply.

Does the patient have any of the following conditions: **Yes** ☐ **No** ☐

- ☐ Fistulas to the body
- ☐ Wound is ischemic
- ☐ Gangrene
- ☐ Osteomylelitis (unless being treated – describe below)
- ☐ Skin cancer in the margins
- ☐ Presence of necrotic tissue, including bone
- ☐ Less than six months to live

Initial Wound Profile

Must be completed by the physician familiar with the client and subscribing the wound care system or the RN.
NOTE: Use additional paper if more than two wounds are currently being treated.

Wound No. 1

Type of wound:
- ☐ Pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

Location:	Stage:	Age of wound:
Date of surgery (if flap or graft): / /	Type of debridement and date: / /	

Wound color:	L x W x D:	Odor:	Drainage:
Tunneling (depth and position):		Undermining (depth and position):	

List all previous wound interventions: (use additional space if necessary):

Wound No. 2

Type of wound:
- ☐ Pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

Location:	Stage:	Age of wound:
Date of surgery (if flap or graft): / /	Type of debridement and date: / /	

Wound color:	L x W x D:	Odor:	Drainage:
Tunneling (depth and position):		Undermining (depth and position):	

List all previous wound interventions: (use additional space if necessary):

Physician Signature:	Date: / /
REQUIRED	
RN Signature:	Date: / /
IF APPROPRIATE	

Effective Date_07302007/Revised Date_06012007

B.59 Statement for Recertification of Wound Therapy System In-Home Use

Patient Name:	Patient Medicaid Number:
Patient Diagnosis:	Date of birth: / /

Home Health Agency Information

Name:	Telephone:
Address:	
TPI:	NPI:
Taxonomy:	Benefit Code:

Indicators for Continuation of Treatment

Must be completed by the physician familiar with the client and prescribing the wound care system. Answer "Yes" or "No" for each question and any answers which apply.

1. Was the initial medical necessity justified by one of the following? **Yes** ☐ **No** ☐

- ☐ Stage III or Stage IV pressure ulcer
- ☐ Pre-operative myocutaneous flap or graft
- ☐ Recent (within 14 days) myocutaneous flap or graft
- ☐ Diabetic ulcer
- ☐ Chronic open wound
- ☐ Venous stasis ulcer

2. Is the wound showing progress? **Yes** ☐ **No** ☐

- ☐ 30 days or longer since myocutaneous flap or graft
- ☐ 30 days with no demonstrated improvement
- ☐ wound healed, no depth
- ☐ wound healing with improvement

Location:	Stage:	Age of wound:	
Wound color:	L x W x D:	Odor:	Drainage:
Tunneling (depth and position):		Undermining (depth and position):	

Wound description (i.e. formation of granulation and date and type of debridement done in last 30 days):

NOTE: Include above information for each wound if more than one.

3. The patient continues to use a pressure-reducing surface. **Yes** ☐ **No** ☐

NOTE: If "No," why not?

4. Name of family member/friend/caregiver who continues to agree to assist patient:

Contraindicators to Continuation of Treatment

(Check any that apply)

Does the patient have any of the following conditions? **Yes** ☐ **No** ☐

- ☐ Fistulas to the body
- ☐ Wound is ischemic
- ☐ Gangrene
- ☐ Osteomylelitis (unless being treated – describe below)
- ☐ Skin cancer in the margins
- ☐ No demonstrable improvement in wound over past 30 days
- ☐ Presence of necrotic tissue, including bone
- ☐ Less than six months to live

Physician Information

Signature:		Date: / /
Name (Print):		Telephone:
License number:	TPI:	NPI:

Effective Date_07302007/Revised Date_06102007

B

B.60 Sterilization Consent Form Instructions (2 Pages)

Per Title 42 *Code of Federal Regulation*s (CFR) 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Ensure all required fields are completed for timely processing.

Fax or mail the Sterilization Consent Form five business days before submitting the associated claim(s) to expedite the processing of the Sterilization Consent Form and associated claim(s).

Fax fully completed Sterilization Consent Forms to Texas Medicaid & Healthcare Partnership (TMHP) at 1-512-514-4229. Claims and appeals are not accepted by fax. Only send family planning sterilization correspondence to this fax number.

Note: Hysterectomy Acknowledgment forms are not sterilization consents and should be faxed to 1-512-514-4218.

Clients must be *at least 21 years of age* when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

Exceptions: (1) Premature delivery - There must be at least 30 days between the date of consent and the client's expected date of delivery. (2) Emergency Abdominal Surgery -There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form. Completion of *all* sections is required to validate the consent form, with only two exceptions:

Exceptions: Race and Ethnicity Designation is requested but not required. The Interpreter's Statement is not required as long as the consent form is written in the client's language, or the person obtaining the consent speaks the client's language. If this section is partially completed, the consent will be denied for incomplete information.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation.

Required Fields

All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization

- Name of Doctor or Clinic
- Name of the Sterilization Operation
- Client's Date of Birth (month, day, year)
- Client's Name (first and last names are required)
- Name of Doctor or Clinic
- Name of the Sterilization Operation
- Client's Signature
- Date of Client Signature - *Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.*

Effective Date_07302007/Revised Date_06012007

Interpreter's Statement (If applicable)

- Name of Language Used by Interpreter
- Interpreter's Signature
- Date of Interpreter's Signature (month, day, year)

Statement of Person Obtaining Consent

- Client's Name (first and last names are required)
- Name of the Sterilization Operation
- Signature of Person Obtaining Consent -The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an *original signature*, not a rubber stamp.
- Date of the Person Obtaining Consent's Signature (month, day, year) - Must be the same date as the client's signature date.
- Facility Name - Clinic/office where the client received the sterilization information
- Facility Address - Clinic/office where the client received the sterilization information

Physician's Statement

- Client's Name (first and last names are required)
- Date of Sterilization Procedure (month, day, year) - Must be at least 30 days and no more than 180 days from the date of the client's consent except in cases of premature delivery or emergency abdominal surgery.
- Name of the Sterilization Operation
- Expected Date of Delivery (EDD) - Required when there are less than 30 days between the date of the client consent and date of surgery. Client's signature date must be at least 30 days prior to EDD
- Circumstances of Emergency Surgery - Operative report(s) detailing the need for emergency abdominal surgery are required
- Physician's Signature - Stamped or computer-generated signatures are not acceptable
- Date of Physician's Signature (month, day, year) - This date must be *on or after* the date of surgery

Paperwork Reduction Act Statement

This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields

- The following provider identification numbers will be required to expedite the processing of the consent form:

  TPI
  NPI
  Taxonomy
  Benefit Code

- Provider/Clinic Phone Number
- Provider/Clinic Fax Number (If available)
- Family Planning Title for Client - Indicate by circling V, X, XIX (Medicaid), or XX

Effective Date_07302007/Revised Date_06012007

B.61 Sterilization Consent Form (English)

Sterilization Consent Form

(Fax Consent Form to 1-512-514-4229)

Client Medicaid or family planning number:	Date Client Signed / / (month/day/year)

Notice: *Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.*

Consent to Sterilization

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible. **I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.** I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ____ (month), ____(day), ____ (year). I, _____, hereby consent of my own free will to be sterilized by _____(doctor or clinic) by a method called _____.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

Client's Signature:	Date of Signature: / / (month/day/year)

Notice: *You are requested to supply the following information, but it is not required.*

Race and Ethnicity Designation

Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Race (mark one or more) ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White

Interpreter's Statement

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice and presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in the _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she has understood this explanation.

Interpreter Signature:	Date of Signature: / / (month/day/year)

Statement of Person Obtaining Consent

Before _____ (client's full name), signed the consent form, I explained to him/her the nature of the sterilization operation known as a _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent:	Date of Signature: / / (month/day/year)
Facility name:	Facility address:

Physician's Statement

Shortly before I performed a sterilization operation upon _____ (name of individual to be sterilized), on_____/_____/_____ at (date of sterilization), I explained to him/her the nature of the sterilization operation _____(specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.) (1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed. (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery - Individual's expected date of delivery:_____/_____ /_____ (month, day, year)

Emergency abdominal surgery (describe circumstances): _____

Physician's Signature:	Date of Signature: / / (month/day/year)

Paperwork Reduction Act Statement

A federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CAR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations.

All Fields in This Box Required for Processing

TPI:	NPI:	Taxonomy:
Benefit Code:	Provider/clinic telephone:	Provider/Clinic fax number:

Titled Billed (check one): ☐ V ☐ X ☐ XIX ☐ (Medicaid) ☐ XX

Effective Date_01152008/Revised Date_09242007

B.62 Sterilization Consent Form (Spanish)

Sterilization Consent Form (Spanish)

(Fax Consent Form to 1-512-514-4229)

Client Medicaid or family planning number:	Date Client Signed / / (month/day/year)

Nota: *La decisión de no esterilizarse que usted puede tomar en cualquier momento, no causará el retiro o la retención de ningún beneficio que le sea proporcionado por programas o proyectos que reciben fondos federales.*

Consentimiento para Esterilización

Yo he solicitado y he recibido información de _____(médico o clínica) sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizada/o es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decido no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F. D. C. o Medicaid, que recibo actualmente o para los cuales seré elegible. **Entiendo que la esterilización se considera una operación permanente e irreversible. Yo he decidido que no quiero quedar embarazada, no quiero tener hijos o no quiero procrear hijos.** Me informaron que me pueden proporcionar otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o. Entiendo que seré esterilizada/o por medio de una operación conocida como _____. Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizada/o no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.
Tengo por lo menos 21 años y nací el ____ (mes), ____(día), ____ (año). Yo, _____, por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada/o por _____ (médico o clínica) por el método llamado _____.
Mi consentimiento vence 180 días a partir de la fecha en la que firme este documento.
También doy mi consentimiento para que se presente esta Forma y otros expediente médicos sobre la operación a: Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales. He recibido una copia de esta Forma.

Firma:	Fecha: / / (mes, día , año)

Nota: *Se ruega proporcione la siguiente información, aunque no es obligatorio hacerlo:*

Definición de Raza y Origen Étnico

Origen étnico ☐ No hispano o latino ☐ Hispano o latino

Raza (marque según aplique) ☐ Natural de Hawaii u otras islas del Pacífico ☐ Indígena americano o indígena de Alaska ☐ Negro o afroamericano ☐ Blanco ☐ Asiático

Declaración Del Intérprete

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada: He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido este consentimiento. También le he leído a él/ella la Forma de Consentimiento en idioma _____ y le he explicado el contenido de esta forma. A mi mejor saber y entender, ella/él ha entendido esta explicación.

Firma:	Fecha: / / (mes, día , año)

Declaración De La Persona Que Obtiene Consentimiento

Antes de que _____(nombre de persona) firmara la Forma de Consentimiento para la Esterilización, le he explicado a ella/él los detalles de la operación _____, para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento. He aconsejado a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente. Le he explicado a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que ella/él no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias..

Firma de la persona que obtiene el consentimiento:	Fecha: /: /: (mes, día , año)
Lugar:	Dirección:

Declaración Del Médico

Previamente a realizar la operación para la esterilización a _____ (nombre de persona esterilizada/o), en _____/_____/_____ (fecha de esterilización: día, mes, año), le expliqué a él/ella los detalles de esta operación para la esterilización _____(especifique tipo de operación), del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación. Le aconsejé a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le expliqué que la esterilización es diferente porque es permanente. Le informé a la persona que sería esterilizada que podía retirar su consentimiento en cualquier momento y que ella/él no perdería ningún servicio de salud o ningún beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene a lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y libre voluntad ser esterilizada/o y parece entender el procedimiento y las consecuencias de este procedimiento. (Instrucciones para uso alternativo de párrafos finales: Utilice el párrafo 1 que se presenta a continuación, excepto para casos de parto prematuro y cirugía abdominal de emergencia cuando se ha realizado la esterilización a menos de 30 días después de la fecha en la que la persona firmó la Forma de Consentimiento para la Esterilización. Para esos casos, utilice el párrafo 2 que se presenta más adelante. Tache con una X el párrafo que no se aplique). (1) Han transcurrido por lo menos 30 días entre la fecha en la que la persona firmó esta Forma de Consentimiento y la fecha en la que se realizó la esterilización. (2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (marque la casilla apropiada y escriba la información requerida):
Parto prematuro - Fecha prevista de parto _____/_____ /_____(mes, día , año)
Cirugía abdominal de urgencia (Describa las circunstancias): _____

Firma del médico:	Fecha: / / (mes, día , año)

Declaración Sobre Ley De Reducción De Trámites

Una agencia federal no debe llevar a cabo o patrocinar la recolección de información, y el público no está obligado a responder a la misma o a facilitar la información, a no ser que dicha solicitud de información presente un número de control válido de la OMB. La carga horaria para el público que completa esta forma variará; sin embargo, se ha estimado un promedio de una hora por cada respuesta, cálculo que incluye el tiempo para revisar las instrucciones, buscar y presentar los datos exigidos y completar la forma. Para enviar sus comentarios sobre la carga horaria estimada o cualquier otro aspecto de la información requerida, escriba a OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.Se debe informar al público que responde a esta forma que la recolección de información solicitada en la misma se autoriza en virtud de 42 CAR parte 50, subparte B, que tiene que ver con la esterilización de personas en programas de salud pública que son financiados por el gobierno federal. El propósito de la recolección de esta información es asegurar que las personas que solicitan la esterilización sean informadas sobre los riesgos, los beneficios y las consecuencias de esta operación, y para asegurar el consentimiento voluntario e informado de todas las personas que se someten al procedimiento de esterilización en programas de salud pública que reciben asistencia federal. Se pide a las personas que llenan la forma que incluyan datos sobre su raza y grupo étnico, aunque esta información no es requerida. Toda la demás información solicitada en esta forma de consentimiento es requerida. Si la persona que llena la forma no proporciona la información requerida o si no firma esta forma de consentimiento, podría resultar en que no recibiera el procedimiento de esterilización financiado por un programa de salud pública patrocinado con fondos federales.Toda la información de datos y circunstancias personales obtenidas por medio de esta Forma son confidenciales y no se divulgarán sin el consentimiento de la persona, en conformidad con todos los reglamentos aplicables de confidencialidad.

All Fields in This Box Required for Processing

TPI:	NPI:	Taxonomy:
Benefit Code:	Provider/clinic telephone:	Provider/Clinic fax number:

Titled Billed (check one): ☐ V ☐ X ☐ XIX ☐ (Medicaid) ☐ XX

Effective Date_01152008/Revised Date_09242007

B

B.63 Texas Medicaid Palivizumab (Synagis) Prior Authorization Request Form

Go to new form

Patient's Name:		Client ID:	
Date of birth: / /	Gender: ☐ M ☐ F	Telephone Number:	
Address:		City:	State:
Parent/Legal Guardian (if applicable):			
Age in months at start of RSV season (as of October 1):		Estimated gestational age at birth: completed weeks	
Requested dates of service—From:	To:	Quantity Requested:	

☐ Clients less than 24 months chronological age at the start of the RSV season can qualify based on criteria to the right. Diagnoses and conditions must be clearly documented in the client's medical record. Date of birth on or after 09/30/2005.	☐ Hemodynamically significant heart disease: (specify ICD-9-CM code): **Or** ☐ Chronic lung disease (CLD)*: (specify ICD-9-CM code): **And** Required any of the following therapies within the past 6 months: ☐ Supplemental oxygen ☐ Digitalis ☐ Steroids (systemic or inhaled) ☐ Diuretics ☐ Mechanical ventilation *CLD was formerly called bronchopulmonary dysplasia. It can develop in pre-term neonates who are treated with oxygen and positive pressure ventilation. Many cases are seen in infants who previously had respiratory distress syndrome (RSD). CLD is characterized by disordered lung growth and a reduction in the number of structures available for gas exchange. CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.
☐ Clients less than 12 months chronological age at the start of the RSV season can qualify based on criteria to the right. Date of birth on or after 09/30/06.	☐ ≤ 28 completed weeks gestational age at birth (specify ICD-9-CM code):
☐ Clients less than 6 months of age at the start of RSV season can qualify based on criteria to the right. Diagnoses, conditions, and risk factors must be clearly documented in client's medical record. Date of birth on or after 03/31/2007.	☐ 29 to 32 completed weeks gestational age at birth (specify ICD-9-CM code): **Or** ☐ 32 to 35 completed weeks gestational age (specify ICD-9 code): **With** the following documented in the patient's medical record**:** ☐ Severe neuromuscular disease (including chronic respiratory failure, 51883) **Or** ☐ Significant congenital anomalies of the airway expected to compromise respiratory reserve **And** *two* of the following: Required any of the following therapies within the past 6 months: ☐ Direct exposure to tobacco smoke or other air pollution ☐ Attends child care ☐ Direct contact with siblings who attend school or child care
☐ Stem cell transplant (specify ICD-9CM Code):	☐ Solid organ transplant (specify ICD-9CM Code):

Additional clinical information about medical necessity that is not provided above:			
Physician Name (printed):			Date: / /
Address:	City:	State:	Zip:
Telephone Number:	Fax Number:		
Physician Signature:		License number:	
TPI:	NPI:	Taxonomy:	Benefit Code:

Effective Date_07302007/Revised Date_09172007

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

B.64 Texas Medicaid Vendor Drug Program Palivizumab (Synagis) Prescription Form

Patient's Name _____ Texas Medicaid Recipient Number _ _ _ _ _ _ _ _ _ _
Date of Birth _____ Gender: ☐ Male ☐ Female
Address (Street) _____
City _____ State _____ ZIP _____ Phone _____ Phone _____
Parent/Legal Guardian Name **(if applicable)** _____

AGE IN MONTHS AT START OF RSV SEASON (AS OF NOVEMBER 1ST) _____	ESTIMATED GESTATIONAL AGE AT BIRTH: _____ COMPLETED WEEKS
CHRONOLOGICAL AGE AT START OF RSV SEASON	**GESTATIONAL AGE AT BIRTH OR DISEASE STATE**
☐ IF < 24 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT. DATE OF BIRTH ON OR AFTER 11/02/2003 (SEE MEDICAID BULLETIN #190 FOR DETAILS RELATED TO CONGENITAL HEART DISEASE DIAGNOSES.)	☐ HEMODYNAMICALLY SIGNIFICANT HEART DISEASE: (SPECIFY ICD-9 CODE(S)) _____ **OR** ☐ CHRONIC LUNG DISEASE: (SPECIFY ICD-9 CODE(S) _____ **AND** AT LEAST ONE OF THE FOLLOWING: ☐ REQUIRED ROUTINE SUPPLEMENTAL OXYGEN WITHIN PAST 6 MONTHS: ☐ REQUIRED ANY OF THE FOLLOWING THERAPIES WITHIN THE PAST 6 MONTHS: ☐ IPRATROPIUM ☐ INHALED BETA 2 AGONIST ☐ METHYLXANTHINES ☐ STEROIDS (systemic or inhaled) ☐ SYMPATHOMIMETICS (e.g., epinephrine, isoproterenol)
☐ IF ≤ 12 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT DATE OF BIRTH ON OR AFTER 10/02/2004	☐ ≤ 28 COMPLETED WEEKS GESTATIONAL AGE AT BIRTH: (SPECIFY ICD-9 CODE): _____
☐ IF ≤ 6 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT DATE OF BIRTH ON OR AFTER 04/02/2005	☐ BETWEEN 28 & 31 COMPLETED WEEKS GESTATIONAL AGE: (SPECIFY iCD-9 CODE): _____ ☐ BETWEEN 32 & 35 COMPLETED WEEKS GESTATIONAL AGE (SPECIFY ICD-9 CODE): _____ AND ONE OF THE FOLLOWING: ☐ SEVERE NEUROMUSCULAR DISEASE: (SPECIFY): _____ ☐ CONGENITAL AIRWAY ANOMALY: (SPECIFY) : _____ ☐ BETWEEN 32 & 35 COMPLETED WEEKS GESTATIONAL AGE (SPECIFY ICD-9 CODE): _____ AND TWO OF THE FOLLOWING: ☐ DIRECT EXPOSURE TO TOBACCO SMOKE OR OTHER AIR POLLUTION ☐ ATTENDS CHILD CARE ☐ DIRECT CONTACT WITH SIBLINGS WHO ATTEND SCHOOL OR CHILD CARE
ADDITIONAL CLINICAL INFORMATION PERTAINING TO MEDICAL NECESSITY NOT OTHERWISE PROVIDED ABOVE:	

Rx: ☐ **Synagis ® (palivizumab) 50mg and/or 100mg vials and Sterile Water for injection 10ml**
Sig: Reconstitute as directed and inject 15mg/kg one time per month. **Quantity:** QS for weight based dosing

☐ Syringes 1ml 25G 5/8" ☐ Syringes 3ml 20G 1"
☐ Epinephrine 1:1000 amp. Sig: Inject 0.01mg/kg as directed ☐ Known Allergies: _____
☐ Other: _____
Sig: _____ **Refills:** _____

Physician Name (printed) _____ Date _____
Address _____
City _____ State _____ ZIP _____ Phone_____

Physician Signature _____ Texas License No. _____

Effective Date_09172007/Revised Date_09172007

B

B.65 Electronic Remittance and Status (ER&S) Agreement (2 Pages)

Before your ER&S Agreement* can be processed, you MUST choose ONE of the following:

* *These changes affect ONLY the ELECTRONIC version of the Remittance & Status Report. To make changes to the PAPER version of the R&S report, contact TMHP Provider Enrollment.*

☐ **Set up INITIALLY** (first time). Use Production User ID*: _____ (9 digits)

☐ **CHANGE** Production User ID FROM: _____ (9 digits)

TO: _____ (9 digits)

☐ **REMOVE** Production ID Remove: _____ (9 digits)

** *The TMHP **Production User ID** (Submitter ID) is the electronic mailbox ID used for downloading your Electronic Remittance & Status (ER&S) reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.*

This information MUST be completed before your request can be processed.

Provider Name *(must match TPI/NPI number)* | Billing TPI Number | Provider Tax ID Number

Provider's Physical Address | Billing NPI Number | Provider Phone Number

Provider Contact Name *(if other than provider)* | Provider Contact Title | Contact Phone Number

Do not complete this block UNLESS the ER&S will be downloaded by anyone OTHER than the provider.

Name of Business Organization to Receive ER&S | Business Organization Phone Number

Business Organization Contact Name | Business Organization Contact Phone No.

Business Organization Address | Business Organization Tax ID

Check each box after reading and understanding the following statements.

If you are unsure about anything that is stated below, contact the TMHP EDI Help Desk at (888) 863-3638.
All three statements must be checked before we can process your Electronic Remittance & Status Agreement.

☐ I (we) request to receive Electronic Remittance and Status information and authorize the information to be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.

☐ I (we) understand that paper formatted R&S information will continue to be sent to my (our) accounting address as maintained at TMHP until I (we) submit an Electronic R&S Certification Request form.

☐ I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Provider Signature | **Date**

Title | **Fax Number**

DO NOT WRITE IN THIS AREA — For Office Use

Input By: _____ Input Date: _____ Mailbox ID: _____

Effective Date_07302007/Revised Date_06012007

Before faxing or mailing this agreement, ensure that all required information is completely filled out, and that the agreement is signed.

Incomplete agreements cannot be processed.

Mail to:

Texas Medicaid & Healthcare Partnership
Attention: EDI Help Desk MC–B14
PO Box 204270
Austin, TX 78720-4270

Fax to:

(512) 514-4228
OR
(512) 514-4230

B

Effective Date_07302007/Revised Date_06012007

B.66 Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Sections I and II (2 Pages)

Note: *Please complete all information in the manner requested to ensure timely processing.* ********Otherwise additional information will be requested. This form is to be used for request of* either *Intrathecal Baclofen or Morphine pump.*

Section I: The following items must be filled out by the treating physician.		
Client name (last, first, M.I.):		
Medicaid number:	Date of birth: / /	
CPT code(s) with description of procedure(s) requested:		
Dates of service being requested:	From: / /	To: / /
Diagnosis or ICD-9 code(s) as related to the prescription:		
Performing Provider Information		
Name:	Telephone (include area code)	
Address:		
Specialty (e.g., pediatric neurosurgeon):		
TPI:	NPI:	
Taxonomy:	Benefit Code:	
Facility Information		
Note*: Provide the facility information below only if it is different from the performing provider's information.*		
Name:	Telephone:	
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	
		/ /
Original Physician's Signature (Stamped signatures not accepted)	Printed name of physician	Date signed
** The completion of this form does not guarantee prior authorization. Once this information is reviewed and a determination has been made, you will receive a written response to the prior authorization request. If a prior authorization number is issued, it will be included in the response.		

Effective Date_07302007/Revised Date_06012007

Note: *Please complete all information in the manner requested to ensure timely processing.* ********Otherwise additional information will be requested. This form is to be used for request of* either *Intrathecal Baclofen or Morphine pump.*

Client name (last, first, M.I.):	
Medicaid number:	Date of birth: / /

Section II: Please attach the following information as it applies to this request. This information must be signed and dated by the physician (stamped signatures will not be accepted).

1. History and Physical—include the following information:

A. Age of onset of signs/symptoms, which are directly related to this request (if requesting baclofen, specify muscle groups affected, degree of spasticity, paralysis, etc.)

B. Prior hospitalizations/treatments for these symptoms or diagnoses

C. Other Diagnoses

D. Current level of functioning in activities of daily living (ADL)

E. Pertinent lab/X-Ray results

F. Client's weight (in kilograms)

G. Family and/or client's role, participation, and compliance with client's care

H. Medications (name, dosage, route, and frequency)

I. Response of client to prior treatments (medications)/surgery/ baclofen/morphine pump

2. Plan of Care

Include information pertinent to the treatment plan. You do not need to duplicate information already contained in the "history and physical" section. You may attach your medical chart "plan of care" for this section if it is succinct, complete, and responds to all of these questions.

A. Medical/surgical management of client (current treatment plan)

1. Medical plan of care (medications, therapy, consultations)

2. Surgical plan of care (e.g., consultations, scheduled surgeries)

3. Recommendation and plan of care with a baclofen/morphine pump (including expected schedule of treatment, anticipated drug dosage, and volume and response evaluation, and, if requesting baclofen, the muscle groups to be treated)

4. Follow-up plan and any long-term alternatives

B. Are there any other treatments, which you expect to be tried, if the baclofen/morphine is ineffective?

C. List the names, specialties, and telephone numbers of other physicians involved in the multidisciplinary care of this client

******The completion of this form does not guarantee prior authorization. Once this information is reviewed and a determination has been made, you will receive a written response to the prior authorization request. If a prior authorization number is issued, it will be included in the response.

Effective Date_07302007/Revised Date_06012007

B.67 Texas Medicaid Refund Information Form

Please attach this completed form to your refund check made payable to TMHP, include a copy of the Medicaid Remittance and Status (R&S) report, and mail to the following address:

Texas Medicaid & Healthcare Partnership
Financial Department
12357-B Riata Trace Parkway
Suite 150
Austin, TX 78727

Date: _____ Refunding provider's name: _____
Provider's TPI: _____ Provider contact name: _____
Provider's telephone number with extension: _____
Provider's e-mail address: _____
Provider's NPI: _____ Taxonomy: _____

Claim Information:

Medicaid claim number (from *R&S*) refund should be applied to: _____
Patient's name: _____
Patient's Medicaid number: _____
Date(s) of service: _____

Reason for the Refund:

_____ Other insurance paid $_____ on this claim. **Attach EOB.** If no EOB available, complete the following:

Insurance company name: _____

Address: _____

Telephone number: _____ Policy number: _____

_____ TMHP audit identified overpayment
_____ Duplicate Medicaid payment
_____ Claim paid on the wrong patient's Medicaid ID number
_____ Claim paid on the wrong provider's Medicaid TPI/NPI/API
_____ Above-named person is not our patient
_____ Billing error
_____ Service was not rendered as billed
_____ Late credit for blood or pharmacy
_____ Medicare adjusted payment
_____ Patient's Medicare eligibility
_____ Other (describe in detail): _____
_____

Effective_Date_07302007/Revised_Date_06012007

B.68 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

Effective Date_07302007/Revised Date_06292007

B.69 THSteps-CCP Prior Authorization Private Duty Nursing 4 or 6 Month Authorization

Client name:	Client Medicaid number:	Date: / /

The following criteria must be met before seeking a 4- or 6-month authorization of private duty nursing (PDN) services. Remember that authorization is a condition for reimbursement; it is not a guarantee. Each nurse provider should verify the continued Medicaid coverage for each client for each month of service.

☐	Client has received PDN services for at least one year.
☐	Client has had no new significant diagnosis, treatment, illness/injury or hospitalization in at least 6 months that would be expected to affect the need for PDN services.
☐	There has been no change in the PDN requests in the previous 6 months.
☐	Client's physician and client/parent/guardian do not anticipate any significant changes in the client's condition for the requested authorization period.
☐	The nurse provider will ensure that a new physician plan of care is obtained every 60 days and will be maintained with the client's record.
☐	The nurse provider will advise TMHP-CCP of any significant changes in the client's condition, treatments or physician orders which occur during the authorization period if the number of PDN hours needs to change.
☐	The client's physician, client/parent/guardian, and nurse provider understand that the authorization may be changed during the authorization period if the client's condition or skilled needs change significantly.

All required acknowledgments must be signed and dated

I have read and understand the above information.

/ /

Signature of the client/parent/guardian	Date

Brief statement of why a 4- or 6-month extension is appropriate for this client:

I have discussed the above information with the client/parent/guardian.

/ /

Signature of nurse provider	Date

To be completed by the client's physician

The above services are medically necessary, the client's condition is stable and this request supports the client's health and safety needs.

/ /

Signature of the client's physician	Date

Printed name:

Telephone:	Fax number:

Mailing address	City, State, and ZIP code

Fax completed request to TMHP-CCP at 1-512-514-4212

Effective Date_09012007/Revised Date_08142007

B.70 THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy

Child's Name:		Medicaid number:	
Has the child received therapy in the last year from the public school system? ☐ Yes ☐ No			Date of birth: / /
Date of Initial Evaluation	PT: / /	OT: / /	SLP: / /
Diagnoses:			

Requested Treatment Plan: Indicate the date(s) of service and frequency per week or month:

Service Type	Service Date(s)		Frequency per week	Frequency per month
	From:	To:		
☐ **PT**	/ /	/ /		
☐ **OT**	/ /	/ /		
☐ **SLP**	/ /	/ /		

New Application: Have treatment goals been developed? ☐ Yes ☐ No

Is the child capable of making measurable progress? ☐ Yes ☐ No

Renewal Application: Has the child made measurable progress during this period? ☐ Yes ☐ No

Is the child capable of making continued measurable progress during this period? ☐ Yes ☐ No

Provider Information		
Name:		
Billing address:		
Physician Information		
Signature:		Date: / /
Name (printed):	TPI No.:	NPI No.:
PT Therapist Information		
Signature:		Date: / /
Name (printed):		Telephone:
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	
OT Therapist Information		
Signature:		Date: / /
Name (printed):		Telephone:
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	
SLP Therapist Information		
Signature:		Date: / /
Name (printed):		Telephone:
Address:		
TPI:	NPI:	
Taxonomy:	Benefit Code:	

Effective Date_07302007/Revised Date_06012007

B.71 THSteps Dental Mandatory Prior Authorization Request Form

Submit to:
THSteps Dental
Prior Authorization Unit
PO Box 202917
Austin, TX 78720-2917

Go to new form

Note: All information is required—print clearly or type	
Patient Information	
Name:	Date of Birth: / /
Address:	
Medicaid Number:	Gender: ☐ **M** ☐ **F**

Check the following diagnostic tools submitted for review with the authorization request:

For restorative and intermediate care facility for the mentally retarded (ICF-MR):

Panorex ☐	Perio Chart ☐	Periapicals ☐	Occlusal Photos ☐

For orthodontic case diagnostic tools submitted:

Models ☐	HLD ☐	Panorex ☐	Documentation ☐	Cephlometric X-ray ☐
FM X-ray ☐	Photos ☐	Other ☐		

Date of service diagnostic tools were produced:

Procedure Code	Tooth Number or Letter	Surface	Charge
			Total

Note: All information is required—print clearly or type	
Signature of dentist:	Date: / /
Printed or typed name of dentist:	Dentist telephone:
Dentist address:	
Dentist Identifying Numbers	
TPI:	NPI:
Taxonomy:	Benefit Code:

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

Effective Date_07302007/Revised Date_06012007

B.72 THSteps Dental Criteria for Dental Therapy Under General Anesthesia (2 Pages)

Total points needed to justify treatment under general anesthesia = 22.

Age of client at time of examination	Points
Less than four years of age	8
Four and five years of age	6
Six and seven years of age	4
Eight years of age and older	2

Treatment Requirements (Carious and/or Abscessed Teeth)	Points
1-2 teeth or one sextant	3
3-4 teeth or 2-3 sextants	6
5-8 teeth or 4 sextants	9
9 or more teeth or 5-6 sextants	12

Behavior of Client**	Points
Definitely negative–unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability	10
Somewhat negative–defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator's hand, refusal to take radiographs	4
Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal reponses and are not indications for treatment under general anesthesia	0
** Requires that narrative fully describing circumstances be present in the client's chart	

Additional Factors**	Points
Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**	15
Failed conscious sedation**	15
Medically compromising of handicapping condition**	15
** Requires that narrative fully describing circumstances be present in the client's chart	

I understand and agree with the dentist's assessment of my child's behavior.

PARENT/GUARDIAN SIGNATURE: _____DATE: _____

Clients in need of general anesthesia who do not meet the 22-point threshold, by report, will require prior authorization.

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client's chart. The client's chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST'S SIGNATURE: _____

DATE: _____License No. _____

Effective Date_01152008/Revised Date_12032007

Medicaid Dental Policy Regarding Criteria for Dental Therapy Under General Anesthesia–Attachment 1

Purpose: To justify I.V. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child's Dental Record.

Elements: Note those required* and those as appropriate**:

1) * Client's Demographics including Date of Birth
2) * Relevant Dental and Medical Health History
   ** including Medical Evaluation Justifying Relevant Medical Condition(s)
3) * Dental Radiographs, Intraoral/Perioral Photography, and/or Diagram of Dental Pathology
4) * Proposed Dental Plan of Care
5) * Signed Consent by Parent/Guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of general anesthesia for dental care has been explained.
6) *The parent/guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist's assessment of their child's behavior
7) ** Other Relevant Narrative Justifying Need for General Anesthesia
8) * Completed Criteria for Dental Therapy Under General Anesthesia form
9) * The dentist's attestation statement and signature may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the chart as a stand-alone form:

"I attest that the client's condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client's record and is available in my office."

REQUESTING DENTIST'S SIGNATURE: _____DATE: _____

Effective Date_01152008/Revised Date_12032007

B.73 THSteps Referral Form Instructions

The referral form assists in relaying correct and pertinent information to the person or agency receiving the referral. It may be mailed or hand-carried by the client. When the form is returned, it should be placed in the client's record.

Receiving/Referring Agencies
The name and address of both agencies should be completed to allow communication if additional information is necessary and to return a completed referral. If the referral is to a physician and the client is not able to name the physician who will be seen, this space may be completed MD/DO.

Identifying Information
This section concerning patient information should be as complete as possible. This section will assist the receiving agency to locate the client.

Reason for Referral
This section should contain information which is relevant to the referral. It may contain an assessment with request for further evaluation, or a request for intervention by a physician, hospital, or other agency involved with the client. Other information pertinent to the referral, such as family history or involvement with other agencies, may also be included.

Release of Information
This section must be signed.

Findings/Services Rendered
This final section provided the receiving agency the vehicle with which to transmit information back to originator of referral. Form may be mailed or carried by the client.

B.74 THSteps Referral Form

Referral date:_____

TO: Name and address of receiving agency or person

FROM: Name and address of person or referring agency

Client's name:_____

Address:_____

Telephone:_____

Name of spouse/parent/guardian

_____

Social Security number:_____

Birth date: _____Sex: (M)____(F)____

DIRECTIONS TO HOME:_____

_____

Marital status: S M W D Sep. Unk.

REASON FOR REFERRAL:

_____

RETURN RESPONSE REQUESTED

Signature/Title

Signature signifies receipt/knowledge of this referral and authorizes the referring agency to release information necessary for its completion, and the referring agency is released from all legal responsibility that may arise from this act.

_____

Signature of Client/Parent/Guardian

FINDINGS AND SERVICES RENDERED:

_____

Signature/Title

_____

Date

1) White - Receiving Agency

2) Yellow - Receiving Agency Response

3) Pink - Client Record

Note: Instructions (L-29a) for use of Referral Form should accompany the document. (HHSC) L-29 Rev. (6/91)

B.75 Tort Response Form

Client Information					
Today's date: / /			Medicaid number:		
Date of birth: / /			Social Security Number:		
Last name:			First name:		
Information Provided By:					
Attorney ☐	Insurance ☐	Provider ☐	Recipient ☐	HHSC ☐	Other ☐
Name:			Telephone:		
Accident Information					
Date of loss: / /	Type of accident:				
Case comments:					
Attorney Information					
Name:			Contact name:		
Street Address:					
City:			State:		Zip Code:
Telephone:			Fax number:		
Insurance Information					
Company name:			Contact name:		
Street Address:					
City:			State:		Zip Code:
Adjuster's name:			Claim number:		
Policyholder:			Policy number:		
Telephone:			Fax number:		

Fax or Mail completed copy to:

Texas Medicaid & Healthcare Partnership
Tort Department
PO Box 202948
Austin, TX 78720-9981
Fax: 1-512-514-4225

Effective Date_01152008/Revised Date_06292007

B

B.76 Ventilator Service Agreement

Client Information		
Name:	Medicaid number:	
Provider Information		
Name:		
NPI:	TPI:	
Ventilator Information		
Date of Purchase: / /	Date of Request: / /	Serial number:
Manufacturer:	Model number:	

Service Agreement

The Manufacturer's recommended preventive maintenance schedule for the ventilator make and model must be submitted with the Ventilator Service Agreement request.

If this is a renewal Ventilator Service Agreement, in addition to the above, the following documentation must also be submitted:

1. Documentation of the monthly ventilator service procedures performed by a respiratory therapist and client assessments by a respiratory therapist.
2. Description of ventilator preventive maintenance performed during the last ventilator service agreement period:

Provider Responsibilities

Provider responsibilities for maintaining the ventilator service agreement Include:

1. Ensure routine service procedures outlined by the ventilator manufacturer are followed.
2. Provide all internal filters, all external filters and all ventilator circuits, (with the exhalation valve), as part of the ventilator service agreement payment.
3. Provide a respiratory therapist and a back-up ventilator on a 24-hour on call basis.
4. Provide monthly visits to the client's home by a respiratory therapist to perform routine service procedures, monitor functioning of the ventilator system and assess client's status. The provider must maintain documentation of monthly visits in accordance with Medicaid Records Retention Policy.
5. Provide a substitute ventilator while the manufacturers recommended preventative maintenance is being performed on the client owned ventilator.

The ventilator service agreement must be prior authorized every six (6) months.

Provider Representative Signature:	Date / /

Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Effective Date_01152008/Revised Date_08072007

B.77 Vision Care Eyeglass Patient (Medicaid Client) Certification Form

I, _____ , certify that:

Printed name of Medicaid client

(Check all that apply:)

☐ I was offered a selection of serviceable glasses at no cost to me, but I desired a type or style of eyewear beyond Medicaid program benefits. *I will be responsible for any balance for eyewear beyond Medicaid program benefits.*

My selection(s) beyond Medicaid benefits were:

1. _____
2. _____
3. _____
4. _____

☐ The glasses that are being replaced were unintentionally lost or destroyed.

☐ I picked up/received the eyewear.

_____ _____

Medicaid client signature | Witness signature

_____ _____

Date | Date

_____

Client Medicaid number

_____

Provider TPI

_____

Provider NPI

Effective Date_01152008/Revised Date_08072007

B.78 Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish)

Yo, _____ , declaro que:

Nombre del cliente de Medicaid

(Marque todos los que apliquen)

☐ Yo necesito reemplazar los lentes que tengo. Me ofrecieron una selección de lentes gratis, pero deseo otro tipo que no está incluido en el programa de Medicaid. *Yo entiendo que tendré que pagar por la diferencia.*

La selección(es) de lentes que escogí fue:

1. _____
2. _____
3. _____
4. _____

☐ Los lentes que van a ser reemplazados no fueron perdidos o destruidos intencionadamente.

☐ Yo recibí los lentes.

_____ _____

Firma del Cliente | Firma de Testigos

_____ _____

Fecha | Fecha

_____

Número de identificación de Medicaid del Cliente

_____

Número de identificación del proveedor (TPI)

_____

Número de identificación del proveedor (NPI)

Effective Date_01152008/Revised Date_08082007

B.79 Wheelchair/Scooter/Stroller Seating Assessment Form (THSteps-CCP/Home Health Services) (Next 6 Pages)

Instructions
A current wheelchair seating assessment conducted by a physician, physical or occupational therapist must be completed for purchase of or modifications (including new seating systems) to a customized wheelchair. Please attach manufacturer information, descriptions, and an itemized list of retail prices of all additions that are not included in base model price. Complete Sections I-VI for manual wheelchairs. Complete Sections I-VII for power wheelchairs.

Client Information	
First name:	Last name:
Medicaid number:	Date of birth:
Diagnosis:	
Height:	Weight:

I. Neurological Factors
Indicate client's muscle tone: ☐ Hypertonic ☐ Absent ☐ Fluctuating ☐ Other
Describe client's muscle tone:
Describe active movements affected by muscle tone:
Describe passive movements affected by muscle tone:
Describe reflexes present:

II. Postural Control				
Head control:	☐ Good	☐ Fair	☐ Poor	☐ None
Trunk control:	☐ Good	☐ Fair	☐ Poor	☐ None
Upper extremities:	☐ Good	☐ Fair	☐ Poor	☐ None
Lower extremities:	☐ Good	☐ Fair	☐ Poor	☐ None

III. Medical/Surgical History And Plans:
Is there history of decubitis/skin breakdown? ☐ Yes ☐ No *If yes, please explain:*
Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.):
Describe other physical limitations or concerns (i.e., respiratory):
Describe any recent or expected changes in medical/physical/functional status:
If surgery is anticipated, please indicate the procedure and expected date:

IV. Functional Assessment:		
Ambulatory status:	☐ Nonambulatory	☐ With assistance
	☐ Short distances only	☐ Community ambulatory
Indicate the client's ambulation potential:	☐ Expected within 1 year	
	☐ Not expected	
	☐ Expected in future within ___ years	

IV. Functional Assessment:		
Wheelchair Ambulation: Is client totally dependent upon wheelchair? ☐ Yes ☐ No *If no, please explain:*		
Indicate the client's transfer capabilities:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent
Is the client tube fed? ☐ Yes ☐ No *If yes, please explain:*		
Feeding:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent
Dressing:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent
Describe other activities performed while in wheelchair:		

V. Environmental Assessment
Describe where client resides:
Is the home accessible to the wheelchair? ☐ Yes ☐ No
Are ramps available in the home setting? ☐ Yes ☐ No
Describe the client's educational/vocational setting:
Is the school accessible to the wheelchair? ☐ Yes ☐ No
Are there ramps available in the school setting? ☐ Yes ☐ No
If client is in school, has a school therapist been involved in the assessment? ☐ Yes ☐ No
Name of school therapist:
Name of school:
School therapist's telephone number:

V. Environmental Assessment
Describe how the wheelchair will be transported:
Describe where the wheelchair will be stored (home and/or school):
Describe other types of equipment which will interface with the wheelchair:

VI. Requested Equipment:	
Describe client's current seating system, including the mobility base and the age of the seating system:	
Describe why current seating system is not meeting client's needs:	
Describe the equipment requested:	
Describe the medical necessity for mobility base and seating system requested:	
Describe the growth potential of equipment requested in number of years:	
Describe any anticipated modifications/changes to the equipment within the next three years:	
Physician/Therapist's name:	Physician/Therapist's signature:
Physician/Therapist's title:	Date:
Physician/Therapist's telephone number: ( ) -	
Physician/Therapist's employer (name):	Physician/Therapist's address (work or employer address):

VII. POWER WHEELCHAIRS:
Complete if a power wheelchair is being requested

Describe the medical necessity for power vs. manual wheelchair:
(Justify any accessories such as power tilt or recline)

Is client unable to operate a manual chair even when adapted? ☐ Yes ☐ No

Is self propulsion possible but activity is extremely labored? ☐ Yes ☐ No
If yes, please explain:

Is self propulsion possible but contrary to treatment regimen? ☐ Yes ☐ No
If yes, please explain:

How will the power wheelchair be operated (hand, chin, etc.)?

Has the client been evaluated with the proposed drive controls?

Does the client have any condition that will necessitate possible change in access or drive controls within the next five years?

Is the client physically and mentally capable of operating a power wheelchair safely and with respect to others?
☐ Yes ☐ No

Is the caregiver capable of caring for a power wheelchair and understanding how it operates?
☐ Yes ☐ No

How will training for the power equipment be accomplished?

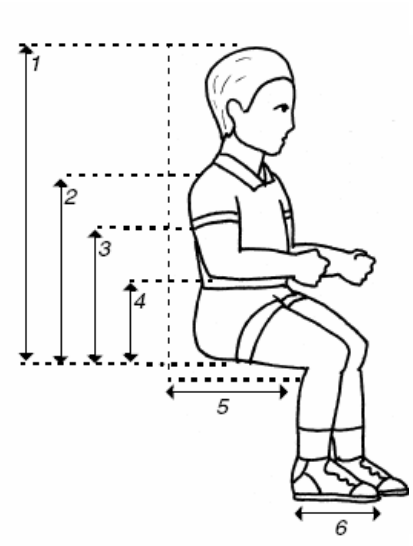
Physician/Therapist's name:	Physician/Therapist's signature:
Physician/Therapist's title:	Date:
Physician/Therapist's telephone number: ( ) -	
Physician/Therapist's employer (name):	Physician/Therapist's address (work or employer address):

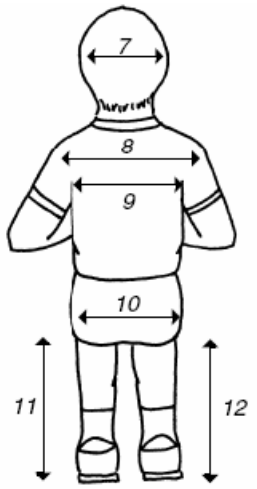
B

Home Health/CCP Measuring Worksheet

General Information	
Client's name:	Date of birth:
Client's Medicaid number:	Height:
Date when measured:	Weight:
Measurer's name:	Measurer's telephone number: ( ) -

Measurements





1:	Top of head to bottom of buttocks
2:	Top of shoulder to bottom of buttocks
3:	Arm pit to bottom of buttocks
4:	Elbow to bottom of buttocks
5:	Back of buttocks to back of knee
6:	Foot length
7:	Head width
8:	Shoulder width
9:	Arm pit to arm pit
10:	Hip width
11:	Distance to bottom of left leg (popliteal to heel)
12:	Distance to bottom of right leg (popliteal to heel)

Additional Comments