Texas Children's® Health Plan

The best decision a family can make.

Prior Authorization Request Form

Fax: 832-825-8760
Toll free fax: 1-844-473-6860

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

Date: _____ Name of person completing form: _____

Office number: _____ Fax number: _____

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

Member ID number: _____

Primary care provider: _____ Provider NPI: _____

Requesting provider name: _____ Provider NPI: _____

Pay to affiliate: _____ Provider NPI: _____

Facility: _____ Provider NPI: _____

Diagnosis: _____ ICD-10 Code(s):_____

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

_____

_____

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

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

_____

HCPCS/CPT 4 code(s):	Visits/units:	Medicaid type of service
code:		
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

Place of service

☐ Inpatient ☐ Observation

☐ Outpatient ☐ Home

☐ Physician's Office ☐ Day Surgery

Other insurance: _____ Other insurance phone number:_____

(Please do not write below this line.)

_____

☐ Approved ☐ Denied: Effective date: _____

Authorization number: _____ Effective date: _____

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