dell children's HEALTH PLAN

Dell Children's Health Plan Nonemergency Ambulance Exception

Submit completed form by fax to: 1-866-249-1271

For behavioral health/intellectual and developmental disabilities services, fax to: 1-866-877-5229

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (*TMPPM*).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents; concealment of a material fact; or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the prior authorization requirements as stated in the relevant Dell Children's Health Plan provider manual and the *TMPPM* and they agree and consent to the Certification above.

☐ We Agree

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Requesting provider information		
Provider name:		Date request submitted:
TPI or NPI:		Taxonomy code:
Contact name:		Ambulance provider:
Phone:	Fax:	Ambulance TPI or NPI:

Member information	
Member name (*Last, First, MI*):	
Member Medicaid ID number:	Date of birth:
Functional, physical or mental health debilitating condition affecting transport:	

Requested services	
HCPCS procedure code:	**Brief description of services:**

Request type

By checking the boxes below and signing this form:

☐I attest that the member has a permanent debilitating condition resulting in the physical or mental inability of the member to perform activities for the remainder of his/her life. For this condition, I am requesting a 180-day prior authorization request.
Additional information:

☐I attest that the member has a debilitating condition resulting in the physical or mental inability of the member to perform activities that can be expected to last for a continuous period of **no less than 12 months**. For this condition, I am requesting a 180-day prior authorization request.
Additional information:

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Documentation

The following attachments must be submitted with the request:

1. *Nonemergency Ambulance Prior Authorization Request*
2. Documentation supporting member's debilitating condition such as, but not limited to:
   - Discharge summary
   - Diagnostic image(s) interpretation report(s) (i.e., MRI, CT, X-rays)
   - Care Plan

Note: Documentation submitted with statement "member has a debilitating condition" is insufficient.

Certification

I certify that the information supplied in this document constitutes true, accurate and complete information and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law, which can result in fines or imprisonment in addition to recoupment of funds paid and administrative sanctions authorized by law.

Physician's printed name:	
Physician's provider identifier (Medicaid TPI or NPI):	
Physician's signature:	Date signed:

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Provider Instructions for Nonemergency Ambulance Exception

This form must be completed by the provider requesting a nonemergency ambulance exception. All nonemergency ambulance exception requests must have the physician document that the member has a debilitating condition and require recurring trips that will extend longer than 60 days.

1. **Requesting provider information** — Enter the name of the entity requesting authorization (e.g., hospital, nursing facility, dialysis facility, physician).
2. **Request date** — Enter the date the form is submitted.
3. **Requesting provider identifiers** — Enter the following information for the requesting provider (facility or physician):
    - Enter the Texas Provider Identifier (TPI) number.
    - Enter the National Provider Identifier (NPI) number. An NPI is a 10-digit number issued by the National Plan and Provider Enumeration System (NPPES).
    - Enter the primary national taxonomy code. This is a 10-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com.
4. **Ambulance provider identifier** — Enter the TPI or NPI number of the requested ambulance provider.
5. **Member information** — This section must be filled out to indicate the member's name in the proper order (last, first, middle initial). Enter the member's date of birth and Medicaid ID number.
6. **Requested services** — Enter the requested Healthcare Common Procedure Coding System (HCPCS) procedure code and a brief description of the requested services. The applicable codes are listed below:

Procedure codes			
A0382	A0398	A0422	A0424
A0425	A0426	A0428	A0430
A0431	A0433	A0434	A0435
A0436	A0999		

7. **Request type** — Check the box for the request type. In the first box, the physician is attesting that the member has a permanent debilitating condition. In the second box, the physician is attesting that the member has a debilitating condition that is expected to last for a continuous period of no less than 12 months. The physician may provide additional information if needed.
8. **Documentation** — The provider must submit the completed *Nonemergency Ambulance Exception* form, the *Nonemergency Ambulance Prior Authorization Request* form and documentation supporting the member's debilitating condition (e.g., surgical report, summary of history, physical therapy evaluation summary).
9. **Physician signature** — The request must be signed and dated by a physician. Stamped or computerized signatures and dates are not accepted. Without a physician's signature, TPI or NPI number provided and the date, the form is considered incomplete. The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.