Prior authorization requirements

Texas | Medicaid

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Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.
Coverage provided by Wellpoint Insurance Company or Wellpoint Texas, Inc.
TX-WP-CD-005858-26-S1870 | March 2026

Utilization management program

Our utilization management (UM) decisions are based on the medical necessity of the requested services or care, as well as the member's coverage according to their benefit plan. We do not compensate, reward, or incent care providers or other individuals, nor do we make decisions about hiring, promoting, or terminating individuals, for restricting benefit coverage for healthcare services or denying coverage for medically necessary healthcare benefits.

We will ensure that services for members are sufficient in the amount, duration, or scope to reasonably achieve the purpose for which services are furnished. We will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member (42 CFR §438.210(a)(ii)).

Regarding UM issues, staff are available at least eight hours a day, Monday through Friday, during normal business hours for inbound collect or toll-free calls and can receive inbound communication by fax after normal business hours. Messages will be returned within one business day. Our staff will identify themselves by name, title, and organization name when initiating or returning calls. TDD/TTY services and language assistance services are available for members as needed, free of charge.

For questions about the UM process, including requesting a free copy of our UM criteria/guidelines, contact Provider Services at 833-731-2162.

Medical Policies, Clinical UM Guidelines, and Medical Drug Benefit Clinical Criteria

There are several factors that impact whether a service or procedure is covered under a member's benefit plan. Medical Policies, Clinical UM Guidelines, and Medical Drug Benefit Clinical Criteria are resources that help us determine if a procedure is medically necessary. These guidelines are available to you as a reference when interpreting prior authorization and claim decisions through the following websites:

- **Medical Policies and Clinical UM Guidelines**
- **Medical Drug Benefit Clinical Criteria**

In addition, the following criteria/guidelines may be used:

- Texas Medicaid Provider Procedures Manual (TMPPM)
- MCG Care Guidelines (based on specific care provider contracts, McKesson InterQual® Level of Care criteria) are also used when no specific health plan medical policies exist.

- Carelon Medical Benefits Management, Inc. guidelines are used for the following types of services:
  - Cardiology
  - Genetic testing
  - Radiation oncology
  - Radiology (high-tech)
  - Sleep studies

Please refer to their website at **https://www.carelon.com/sign-in-or-register** for additional information.

- Behavioral Health uses the American Society for Addiction Medicine (ASAM) Patient Placement Criteria for substance use disorder treatment authorizations, with the exception of detoxification, which uses MCG Care Guidelines.
- Superior Vision of Texas uses health plan criteria and guidelines for medical/surgical reviews.

The prior authorization catalog is a comprehensive, searchable document containing a list of codes and code descriptions and an effective date for each prior authorization. The catalog can be viewed on our provider website in the Prior Authorization Requirements webpage (*Medicaid and CHIP Precertification Effective dates*).

Federal law, state law, contract language, including definitions and specific contract provisions/exclusions, Centers for Medicare & Medicaid Services (CMS) requirements, as well as the Texas Medicaid Provider Procedures Manual (TMPPM), **tmhp.com/resources/provider-manuals/tmppm**, are used when determining eligibility for coverage and supersede any other UM criteria.

Precertification Lookup Tool and submission portal

Determine if specific outpatient procedures and/or services require prior authorization through the Precertification Lookup Tool, which can be found on Availity Essentials through Payer Spaces or the health plan provider website through the following link:

Precertification Lookup Tool: **provider.wellpoint.com/tx**> Resources > Precertification lookup tool

Prior authorization requests or notifications can be submitted digitally through Availity Essentials, which is the preferred method.

Availity Essentials: **https://www.Availity.com**

Inpatient elective and non-emergent admissions always require prior authorization. All elective services provided by or arranged at a nonparticipating provider or facility require prior authorization, except for emergency medical conditions, emergency behavioral health conditions, and minimum required maternity stays where a prior authorization is not required. Some services/procedures have Medicaid allowable limits or age restrictions and should be verified through the Texas Medicaid & Healthcare Partnership (TMHP) Texas Medicaid Provider Procedures Manual (TMPPM).

If you have any questions, please contact Provider Services at **833-731-2162**. Staff are available Monday through Friday from 8 a.m. to 5 p.m. local time, excluding state-observed holidays. Providers may leave a confidential voicemail after hours, and messages will be returned within the next business day.

Additional information is available in the Prior Authorization Contact Information section of this document and is also available on the provider website.

Required documentation

A completed prior authorization request is required to eliminate delays in processing, which includes all required **essential information, documentation, current clinical information, and a signed authorization form by the requesting provider**.

The following essential information, per HHSC Uniform Managed Care Manual Chapter 3.22, is required for all prior authorization request submissions:

- Member name
- Member number or Medicaid/CHIP number
- Member date of birth
- Requesting provider's name and NPI
- Service requested — CPT®, HCPCS, or Current Dental Terminology (CDT)
- Service requested start and end date(s)
- Quantity of service units requested based on the CPT, HCPCS, or CDT requested

To prevent delays, the health plan requests the following information be included with the request to allow for timely processing:

- Rendering provider's name, NPI, and TIN

- Diagnosis code
- Physician signature

These are essential fields we need to include for prior authorization in our system.

Note: Requests that have essential information missing, incorrect, or illegible will be considered incomplete, and the following will occur:

- The requesting provider will receive a notification that the submitted request could not be processed due to missing essential information.
- The notification will explain why the submitted request was not processed as submitted and will include instructions to resubmit the prior authorization request with complete essential information.
- The request will be processed when the requested information is received.
- The date we receive the fully completed request will be designated as the prior authorization request received date.

To ensure timely processing, care providers should respond to requests for missing or incomplete information promptly.

Additional information is available in the *Forms and Documentation Required for Prior Authorization Requests* section of this document.

Information needed for a member who is hospitalized

For services or equipment needed for the care of the hospitalized member immediately after discharge, ensure all required documentation is submitted with the request along with any required signatures to prevent delays in processing. For more information, please refer to the Discharge Planning section of this document.

Submission timelines

Initial requests

It is recommended to submit prior authorization and all supporting documentation at least three business days before the start of care. Failure to follow notification rules may lead to an administrative denial. More information can be found in the Administrative Denials section of this document.

The **start of care** (SOC) date is the date agreed upon by the physician, the service provider, and the member or responsible adult and is indicated on the submitted prior authorization request as the SOC date.

The SOC date may include prior authorization requests for home health skilled nursing, and aide services, private duty nursing (PDN), physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services. These services may require the care provider to assess the member and initiate care within three business days of the SOC date for initial or new PDN services, prior to submitting a prior authorization request.

During the prior authorization process, care providers are required to deliver the requested services from the SOC date. Exceptions to the start of care date may include requests for home health skilled nursing, aide services, PDN, PT, OT, and ST services. Additional information regarding exceptions is discussed below.

Exceptions:

- **Therapy (PT/OT/ST) services**: Initial prior authorization requests must be received no later than five business days from the date therapy treatments are initiated. Requests received after the five-business-day period will not be eligible for reimbursement for dates of service that occurred before the date that the prior authorization request was received.
- **Home health skilled nursing**: Following the RN's initial assessment or evaluation of the client in the home setting for home health service needs, the agency-employed RN who completed the home evaluation must contact the health plan for prior authorization within three business days of the SOC.
- **Private duty nursing**:
  - Initial requests must be submitted within three business days of the SOC date.
  - Initial requests may be prior authorized for a maximum of 90 days.
  - Completed initial requests must be received and dated by the Prior Authorization department within three business days of the SOC:
    - The request must be received by the Prior Authorization department no later than 5 p.m. CT on the third day to be considered received within three business days.
    - If a request is received more than three business days after the SOC, or after 5 p.m. CT on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

Prior authorization recertification process

A physician or healthcare provider can submit a medical prior authorization recertification request at least every 60 calendar days prior to the expiration of the current authorization of service(s) on file.

Exceptions

The health plan requires that prior authorization recertification requests be received up to 30 calendar days prior to the expiration of the current authorized service(s).

- PT, OT, and ST:
  - A complete recertification request must be received no earlier than 30 calendar days before the current authorization period expires. Requests for recertification services received after the current authorization expires will not be eligible for reimbursement for dates of service that occurred before the date the submitted request was received.
- PDN/Prescribed Pediatric Extended Care Centers (PPECC):
  - A recertification request must be submitted at least seven calendar days before, but no more than 30 calendar days before, a current authorization period will expire.
  - All authorization timelines apply to recertifications.
  - Completed extension requests must be received and dated by the Prior Authorization department at least seven calendar days before, but no more than 30 days before, the current authorization expiration date.
    - The request must be received by the Prior Authorization department no later than 5 p.m., CT, on the seventh day, to be considered received within seven calendar days.
    - If a request is received less than seven calendar days before the current authorization expiration date, or after 5 p.m. CT on the seventh day, authorization is given for dates of service beginning no sooner than seven calendar days after the receipt of the completed request by the Prior Authorization department.

Extension process

If the member requests an extension, there is justification for needing additional information, or an extension is in the best interest of the member, the health plan may extend the timeframe up to 14 calendar days for standard authorization requests.

For expedited extensions, the health plan can extend the 72-hour timeframe up to 14 calendar days if the member requests an extension or there is a justification for needing additional information, and the extension is in the best interest of the member.

Prior authorization review

Upon receipt of a request for prior authorization, an assistant verifies eligibility and benefits before forwarding it to the nurse or other qualified reviewer. The reviewer examines the request and supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures using criteria/guidelines. When the clinical information received meets medical necessity criteria, we issue a reference number to the requesting provider.

Prior authorization not required

If a request is submitted for a service for which prior authorization is not required, the provider will receive a response stating that prior authorization is not required. This is not an approval or a guarantee of payment. Claims for services are subject to all plan provisions, limitations, and patient eligibility at the time services are rendered.

Incomplete prior authorization requests

If the prior authorization documentation is incomplete or inadequate, the reviewer is unable to process the request.

In such cases, we will notify the provider and member in writing no later than three business days after receiving the prior authorization request to submit the additional documentation needed to make a decision. A notice will be sent to the member based on their preferred method of receiving prior authorization notices. If the member does not select a preferred method, the notice will be sent by mail.

The written request for additional information will include the following information:

- A statement that the health plan has reviewed the prior authorization request and is unable to make a decision about the requested services without the submission of additional information.
- A clear and specific list and description of the incomplete documentation/information that must be submitted in order to consider the request complete.
- An applicable timeline for the provider to submit the missing information.
- Information on the manner through which a provider may contact the health plan.

We may also contact the provider by phone to obtain the information necessary to resolve the incomplete request.

The final determination of the prior authorization request will be made within three business days after the missing information is received. The requested SOC date will be honored if the provider submits a complete request within the timeline specified in this section and the Determination Timelines section of this document, and the health plan has confirmed that the services meet medical necessity.

If no additional information is received by the end of the third business day from the date the health plan sent the notice to the provider, and the prior authorization request results in an adverse determination, we will refer the request for medical director review with all received information, no later than seven business days after the prior authorization request date.

The medical director will make a determination based on the information previously received within three business days of the referral, but no later than the tenth business day after the prior authorization request date. If a holiday causes the process to exceed 14 calendar days, we will adjust the timeline accordingly to ensure the determination is made within 14 days.

Additionally, if the request does not meet the criteria for approval, the requesting provider will be given the opportunity to discuss the case with the medical director before the denial is issued. For information on this process, refer to the Peer-to-Peer Review Process section of this document.

Determination timelines

Utilization review timeliness standards are as follows:

Program	Authorization type	Decision time frame
Medicaid	Routine/non-urgent	Three business days
CHIP	Routine/non-urgent	Two business days (approval) Three business days (adverse determination)
Medicaid and CHIP	Urgent/expedited	Three calendar days
Medicaid and CHIP	Concurrent	One business day
Medicaid and CHIP	Post-service	30 calendar days

- Medicaid notifications:
  - A written notice of final determination will be provided no later than the next business day following a prior authorization request determination.
- CHIP notifications:
  - For routine and urgent approvals, written/letter notification is required no later than the second business day after the date of the request.
  - For a member who is not hospitalized at the time of an adverse determination, notification will be provided within three business days in writing to the requesting provider and the member.

Medicaid/CHIP:

- For a member who is hospitalized at the time of the request, notification will be provided within one business day of receiving the request for services or equipment that will be necessary for the care of the member immediately after discharge, including if the request is submitted by an out-of-network provider, provider of acute care inpatient services, or a member.
- Notification will be provided within one hour of receiving the request for post-stabilization or life-threatening conditions, except for emergency medical conditions and emergency behavioral health conditions where a prior authorization is not required.
- Providers can confirm that an authorization is on file by accessing Availity Essentials or by contacting Provider Services at **833-731-2162**. If coverage of an admission has not been approved, the facility should contact Provider Services to resolve the issue.
- Per 42 CFR §438, Subpart F, a prior authorization of a requested service that is denied, reduced, or terminated must follow the appeal process for reconsideration of the decision to ensure compliance with federal and state regulations and to protect member rights. The appeal process review must be initiated by the member or the member's representative. Appeal process information is available in the determination notice, along with an explanation of the medical director's decision.

Expedited requests

A member or physician may request to expedite a determination when the member, or member's physician, believes that waiting for a decision under the standard time frame could cause any of the following:

- Serious jeopardy to the life, health, safety, or the member's ability to regain maximum function, based on a prudent layperson's judgment.
- Serious jeopardy to the life, health, or safety of the member or others, due to the member's psychological state.

- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- In the case of a pregnant woman, serious jeopardy to the life, health, or safety of the fetus.
- In the opinion of a practitioner with knowledge of a member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. The practitioner must be allowed to act as the authorized representative of that member.

The following situations are examples that do not meet the criteria for an expedited request:

- The date of service is greater than one week from the request date.
- Clinical documentation does not support the criteria for an expedited request as defined above.
- Any request for therapy (occupational, speech, or physical therapy) is greater than two days from the request date.

Inpatient admission reviews

For inpatient admissions, our utilization review clinician determines the member's medical status through communication with the hospital's utilization review department via fax, telephone, or by accessing electronic medical records. Appropriateness of stay is documented, and a concurrent review is initiated.

Cases that do not meet medical necessity or involve quality of care concerns may be referred to the medical director for review. If a case does not meet medical necessity criteria, the attending provider will have the opportunity to discuss the case with the medical director before a final decision is made. For additional information, refer to the Peer-to-Peer Review Process section of this document. When appropriate, members may be referred to a Population Health Program.

Information needed for a member who is hospitalized

For services or equipment necessary for the care of the hospitalized member immediately after discharge, ensure that all required documentation is submitted with the request, along with any necessary signatures, to eliminate delays in processing. For additional information, please refer to the Discharge Planning section of this document.

Inpatient concurrent reviews

Each network hospital will have an assigned UM clinician who will conduct a concurrent review of the hospital medical record to determine the authorization of coverage for a continued stay. The review will be performed by fax, telephone, or by accessing electronic medical records.

The UM clinician will conduct continued stay reviews and review discharge plans.

We will authorize the covered length of stay based on the clinical information supporting the continued stay. Exceptions will be made for confinements when the length of stay is predetermined by state law. Examples of confinement and/or treatment include Cesarean section or vaginal deliveries. Exceptions are made by the medical director on a case-by-case basis.

When the clinical information received meets medical necessity criteria, approved days and bed level (if appropriate) coverage will be communicated to the hospital for the continued stay. If medical necessity criteria are not met for the ongoing inpatient stay, the medical director will give the attending physician the opportunity to discuss the case prior to making a determination. For additional information, refer to the Peer-to-Peer Review Process section of this document.

If the medical director's decision is to deny the request, the appropriate notice of action will be mailed to the hospital, treating or attending practitioner, and member. The notice of action includes an explanation of the member's appeal rights and state fair hearing/Independent Review Organization (IRO) rights and process.

Peer-to-peer review process

Before issuing an adverse determination, a medical director will provide a reasonable opportunity for the requesting provider to discuss the member's treatment plan and the clinical basis for the medical necessity decision. If you receive a notification that a case is under review and wish to discuss it with our medical director, please contact the appropriate department listed below.

Contact numbers:

- Physical health: **817-861-7768**
- Behavioral health: **844-719-1806**

Staff are available at least eight hours a day, Monday through Friday, during normal business hours.

Be prepared to provide the following information:

- Name of person/physician our medical director needs to call
- Contact number
- Convenient time for a return call
- Authorization/reference number for the case
- Member's name, DOB, and the health plan ID number

If you or your office staff reach our voicemail, leave the name of the best contact person and their phone number so we can reach out for additional information. The medical director will make every effort to return calls within one business day.

The peer-to-peer review timeline is as follows:

- No less than one business day prior to issuing a prospective utilization review adverse determination
- No less than five business days prior to issuing a retrospective utilization review adverse determination
- Prior to issuing a concurrent or post-stabilization review adverse determination

If the notification received indicates that the case was denied, the case must follow the appeal process outlined in the denial letter received.

If services are not approved based on medical necessity, the appropriate notice of action will be mailed to the member, the servicing provider, and the requesting/ordering provider. The notice includes an explanation of the medical director's determination and the member's internal appeal rights and state fair hearing/external independent review rights and process.

Administrative denials

An administrative denial is a denial of services for reasons other than medical necessity. These denials occur when a contractual requirement is not met, such as late notification of admissions, failure to obtain prior authorization, or benefit limitations.

If the health plan overturns its administrative decision, the case will be reviewed and, if approved, the claim will be reprocessed, or the requester will be notified of the action that needs to be taken.

Discharge planning

Discharge planning helps care providers coordinate the member's discharge when acute care (hospitalization) is no longer needed, ensuring a smooth transition from inpatient to outpatient services to improve health outcomes for our members.

Our UM clinician will assist in coordinating discharge planning needs with the hospital utilization review staff and attending physician. The attending physician is responsible for coordinating with the member's care provider(s) regarding follow-up care after discharge, and the care provider(s) must contact the member to schedule all necessary follow-up appointments.

In a behavioral health discharge, the attending facility must also ensure the member has scheduled a follow-up appointment with a HEDIS®-qualified behavioral health provider. The follow-up visit should take place within seven calendar days of discharge.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

When additional or ongoing care is necessary after discharge, we work with the care provider to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility, such as a:

- Hospice facility
- Convalescent facility
- Home healthcare program (for example, home IV antibiotics) or skilled nursing facility

When the care provider identifies medically necessary and appropriate services for the member, we will assist the care provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

For prior authorization requests for a member who is hospitalized at the time of the request, clearly document at the top of the request that the member is hospitalized and has discharge planning needs. To prevent delays in processing, ensure all required documentation is submitted with the request, including any necessary signatures, to the appropriate department listed below.

Contact numbers (fax):

- Inpatient Discharge Planning — Physical Health: **888-708-2599**
- Inpatient Discharge Planning — Behavioral Health: **844-430-6805**

Staff are available at least eight hours a day, Monday through Friday, during normal business hours.

Discharge plan authorizations for ongoing outpatient care follow nationally recognized standards of care and medical necessity criteria. Authorizations include, but are not limited to, transportation, home health, DME, pharmacy, follow-up visits to practitioners, and outpatient procedures.

Medicaid/CHIP prior authorization contact information

Requests for prior authorization may be submitted for review and approval as indicated below:

- Digital submission (preferred method): **https://www.Availity.com**
- Inpatient/outpatient surgeries; other general requests:
  - Fax: **800-964-3627**
  - Phone: **833-731-2162**
- Inpatient discharge planning (fax only):
  - Physical Health: **888-708-2599**
  - Behavioral Health: **844-430-6805**
- Specialized Care Services (fax only):
  - Back and spine procedures: **800-964-3627**
  - DME: **866-249-1271**
  - Home health nursing (PDN, SNV, HHA): **866-249-1271**
  - Medical injectable/infusible drugs: **844-512-8995** (for additional information, refer to the Pharmacy Prior Authorizations document on our provider website)
  - Pain management injections and wound care: **866-249-1271**
  - Therapy (physical, occupational, and speech): **844-756-4608**
- Behavioral Health Services:
  - Digital submission (preferred method): **https://www.Availity.com**
  - Behavioral Health — Inpatient: **844-430-6805** (fax)
  - Behavioral Health — Outpatient: **844-442-8010** (fax)
- Carelon Medical Benefits Management, Inc.:
  - Phone: **833-342-1260**
  - Online: **https://www.carelon.com/sign-in-or-register**
    - Cardiology
    - Genetic testing
    - Radiation oncology
    - Radiology (high-tech)
    - Sleep studies
- Superior Vision of Texas (Medical/Surgical):
  - Fax: **855-313-3106**
  - Email: ecs@superiorvision.com
- Nursing Facility: **844-206-3445** (fax)
- Ambulance Transportation (nonemergent):
  - Physical Health — nonurgent: **866-249-1271** (fax)
  - Behavioral Health — nonurgent: **844-442-8010** (fax)
  - Urgent: **833-731-2162** (phone)

  - For additional information, refer to the Ambulance Transportation Services (Nonemergent) section of the Medicaid/CHIP provider manual.
- STAR Kids Long-Term Services and Supports (LTSS)/Personal Attendant Services (PAS):
  - Fax: **844-756-4604**
  - STAR Kids Urgent Services: **866-696-0710** (phone)
- STAR+PLUS:
  - LTSS/PAS requests are to be submitted by service area (fax only):
    - Jefferson: **888-220-6828**
    - Lubbock: **888-822-5761**
    - Nueces: **888-822-5790**
    - West RSA: **888-822-5761**
  - STAR+PLUS Urgent Services: **877-405-9872** (phone)
- Urgent Services: **833-731-2162** (phone)

For questions, contact Provider Services at **833-731-2162**. Staff are available Monday through Friday from 8 a.m. to 5 p.m. local time, excluding state-observed holidays. You may leave a confidential voicemail after hours, and your call will be returned the next business day.

Documentation and forms required for prior authorization requests are available on our provider website at **https://provider.wellpoint.com/tx**.

Member assistance with prior authorizations

Members who have questions regarding prior authorizations may contact Member Services. Members can also live chat with a representative or send a secure message once a member logs into their account:

- CHIP, STAR, STAR+PLUS: **833-731-2160** (**TTY 711**), available Monday through Friday from 7 a.m. to 6 p.m. CT
- STAR Kids: **844-756-4600** (**TTY 711**), available Monday through Friday from 8 a.m. to 6 p.m. CT

If you have any questions regarding pharmacy prior authorizations/preapprovals, contact Pharmacy Member Services, available 24/7, using the information below:

- CHIP, STAR, STAR+PLUS: **833-235-2022** (**TTY 711**)
- STAR Kids: **833-370-7463** (**TTY 711**)

Forms and documentation required for prior authorization requests

To request a prior authorization, we will accept the following standard forms:

- The health plan's Medicaid Prior Authorization Request Form
- Texas Standard Prior Authorization Request Form for Health Care Services

The provider website includes links to forms under the Forms section.

Other forms available on the provider website include:

- Therapy Prior Authorization Request Form
- Mental Health Targeted Case Management & Rehabilitative Services Form
- Behavioral health:
  - Initial Review Form
  - Concurrent Review Form
  - Psychological Testing Request Form
  - Neuropsychological Testing Request Form
  - Treatment Plan Request Form for Autism Spectrum Disorders
- Nonemergency ambulance:
  - Nonemergency Ambulance Prior Authorization Request Form
  - Nonemergency Ambulance Exception Form
- Pharmacy:
  - Texas Standard Prior Authorization Request Form for Prescription Drug Benefits
  - Medical Injectables Prior Authorization Form

The following table outlines the required forms and documentation needed for prior authorization requests. Current clinical documentation includes, but is not limited to, applicable progress notes, imaging reports, lab or test reports, and consultation reports.

This list does not represent whether the service requires prior authorization or is a covered benefit. Verification that the service/procedure requires prior authorization is recommended prior to submitting the request.

Note: For any specified service with a change in provider, a signed notification by the member will be required.

Forms and documentation required for prior authorization requests

Service	Forms	Documentation
Abortion	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Acupuncture	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Adaptive Equipment/Aids	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation • If applicable, documentation of primary insurance denial of coverage of services • For STAR+PLUS and STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.
Adult Day Care/Day Health Services	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.

Service	Forms	Documentation
Adult Foster Care	• N/A	• For STAR+PLUS /STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.
Allergy Testing	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Allergy Treatment	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Ambulatory Surgical Center services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Ambulance – NEMT	• Completed Nonemergency Ambulance Prior Authorization Request Form • If applicable, the Nonemergency Ambulance Exception Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual • Please note, completed forms may not be submitted by ambulance provider as per Texas Medicaid Provider Procedures Manual.

Service	Forms	Documentation
Anesthesia	Dental (Age 6 and under): • Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional Requirements: • Criteria for Dental Therapy Under General Anesthesia Form • THSteps Dental Mandatory Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual
Applied Behavior Analysis (ABA)	• Completed Treatment Plan Request Form for Autism Spectrum Disorders; or • CCP Prior Authorization Request Form	• Current signed Physician ABA Referral • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual
Assisted Living/Residential Care	• N/A	• For STAR+PLUS and STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.
Assistive/Augmentative Communication Devices	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual

Service	Forms	Documentation
Attendant Care Services	• N/A	• For STAR+PLUS and STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.
Audiology/Hearing Aids, Supplies & Fittings	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual
Bariatric Surgery	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation (Preoperative psychological evaluation) • Surgery must be provided by a facility in Texas that is one of the following: – Accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). – A children's hospital that has a bariatric surgery program and provides access to an experienced surgeon who employs a team that is capable of long-term follow-up of the metabolic and

Service	Forms	Documentation
		psychosocial needs of the client and family.
Behavioral Health – Crisis Intervention	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Behavioral Health – Crisis Stabilization	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Behavioral Health – Hospital Based Detoxification Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Behavioral Health – Hospital Based Services – MD Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Behavioral Health – Hospital Based Services – Inpatient Professional	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Behavioral Health – Inpatient – Psychiatric/ Chemical Dependency	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Behavioral Health – Intensive Outpatient Program (IOP),	• Completed Medicaid Prior Authorization Request Form; or	• Current signed Physician Order or designee • Current clinical documentation

Service	Forms	Documentation
Psychiatric	• TDI Standard Prior Authorization Request Form	
Behavioral Health – Substance Abuse/Chemical Dependency	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Behavioral Health – Outpatient/Ambulatory Detoxification Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Behavioral Health – Outpatient Mental Health – MD Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Behavioral Health – Outpatient Substance Abuse	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Behavioral Health – Partial Hospital, Psychiatric	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Behavioral Health – Psychological Testing	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation

Service	Forms	Documentation
Behavioral Health – Respite Care	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order or designee • Current clinical documentation
Birthing Center	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Blood Administration and Other Blood Products	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Bone Mass/Density Study – Bone Biopsy/Photon Absorptiometry	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Botox Injections	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Breast Reduction	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Burn Pressure Garments	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation

Service	Forms	Documentation
Cardiac Rehabilitation Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual.
Chemotherapy	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Chiropractic Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Chore Services	• N/A – Not a benefit	• N/A
Circumcisions	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Clinical Trials	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Cochlear Implants	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual.

Service	Forms	Documentation
Colorectal Cancer Screening: • Barium Enema • Flexible Sigmoidoscopy • FOBT (Fecal Occult Blood Test) • Screening Colonoscopy	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Corrective Vision Surgery	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Court Ordered Services	• Notification from Courts	• Current signed Court Order • Current clinical documentation (if available)
Deep Brain Stimulators	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Dental – Routine	• Dental MCO to review.	
Dental Services – Medical/Accidental	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form; and • Criteria for Dental Therapy Under General Anesthesia Form	• Health Plan reviews for Level 4 sedation/general anesthesia and facility for 6 years of age and under. • Dental MCO to review for procedure.
Waiver Dental Services	• DentaQuest to review	• For STAR+PLUS members requesting LTSS services, the member/ legally authorized representative must request the services, and an unmet

Service	Forms	Documentation
		need must be identified on assessment by the LTSS team.
Dermatology services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Diabetic Screening	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Diabetic Supplies	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual. • See pharmacy guidelines for glucometer and glucometer supplies For Service Provider changes: • Change of provider letter (Client Choice Statement) – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements

Service	Forms	Documentation
Diagnostic Testing Laboratory	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Dialysis at Free-Standing Clinic	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Dialysis (ESRD) – Locations Other Than Free-Standing Clinics	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
DME – Durable Medical Equipment	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional requirements: • Home Health Services (Title XIX) DME/ Medical Supplies Physician Order Form • For Wheelchairs, including Power Wheelchairs: Wheelchair/Scooter/ Stroller Seating Assessment Form (THSteps-CCP/Home Health Services) • Applicable forms as per Texas Medicaid Provider Procedures Manual	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual. Miscellaneous codes (for example, E1399), either the Title XIX form or a detailed and itemized list of parts with descriptions, quantity, and cost must be submitted. Custom Wheelchairs: • Documentation must include either the Title XIX or a detailed and itemized list of parts, quantity, and cost

Service	Forms	Documentation
		• If applicable, documentation of primary insurance denial of coverage of services For Service Provider changes: • Change of provider letter ("Client Choice Statement") – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
DME and Supplies Exceptional Circumstances Provision (members 21 years of age or older)	• Completed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form, Special Medical Prior Authorization (SMPA) Request Form, Prior Authorization Request for Oxygen Therapy Devices and Supplies, Wound Care Equipment and Supplies Order Form etc.	To request prior authorization for home health DME and supplies under the Exceptional Circumstances provision, providers must submit a written notice to the health plan. The written notice must include: • Completed copies of all of the necessary forms for the requested home health DME or supplies, such as the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form, Special Medical Prior Authorization (SMPA) Request Form, Prior Authorization Request for Oxygen Therapy Devices and Supplies, Wound Care Equipment and Supplies Order Form, etc. The forms

Service	Forms	Documentation
		must be signed and dated by the prescribing physician or allowed practitioner, along with a cover letter indicating the forms are being submitted under the Home Health DME and Supplies Exceptional Circumstances provision. • The client's specific diagnosis, medical needs, and the reasons why they can only be met by the requested home health DME or supply. • A clear, concise description of the requested DME or supply. • The manufacturer's suggested retail price (MSRP) for the requested DME or supply or an invoice documenting the provider's cost. • Letters of Medical Necessity (LOMN) from the client's prescribing physician and other clinical professionals, as appropriate, documenting the alternative measures and alternative DME or supplies that have been tried and have failed to meet the client's medical needs, or have been ruled out, and an explanation of why they have failed or have been ruled out. For Service Provider changes: • Change of provider letter (Client Choice Statement)

Service	Forms	Documentation
		– Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Donor Human Milk	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional requirements: • Donor Human Milk Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual
Drugs/Biologicals (Non-Self Administered)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Early Childhood Intervention (ECI) Services	• None	• The health plan will pay for all ECI covered services in the amount, duration, scope, and service setting established by the Individual Family Service Plan (IFSP)
Electroconvulsive Therapy (ECT)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Emergency Services	• None	• None
Enteral Nutrition	• Completed Medicaid Prior Authorization Request Form; or	• Current signed Physician Order

Service	Forms	Documentation
	• TDI Standard Prior Authorization Request Form Additional Requirements: • CCP Prior Authorization Request Form (if applicable)	• Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual For Service Provider changes: • Change of provider letter ("Client Choice Statement") – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
EPSDT/Texas Health Steps Services performed by a Texas Health Steps Provider	• N/A	• N/A
Erectile Dysfunction Treatment	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Experimental and Investigational	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Family Planning Benefit, Consults, Supplies, and Equipment	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation • No prior authorization for family planning services available for STAR, STAR Kids, and STAR+PLUS

Service	Forms	Documentation
		nondual (not covered for CHIP)
Financial Management	• N/A	• For STAR+PLUS and STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.
Federally Qualified Healthcare Clinic (FQHC) Services	• None	• None
Genetic Testing or DNA Testing	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Glaucoma Screening	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
HIV/AIDS Testing/Treatment	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation

Service	Forms	Documentation
Home Delivered Meals	• N/A	• For STAR+PLUS and Prog STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.
Home Environment Evaluation	• N/A	• For STAR+PLUS and STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.
Home Infusion/Total Parenteral Nutrition	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual For Service Provider changes: • Change of provider letter (Client Choice Statement) – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements

Service	Forms	Documentation
Home Modification	• N/A	• For STAR+PLUS and STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.
Hospice Care	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	STAR, STAR Kids, and STAR+PLUS, hospice care is through the Texas Health and Human Services Commission (HHSC). For CHIP members, the following is required for inpatient services: • Current signed Physician Order • Current clinical documentation Notification is required for outpatient hospice services.
Hyperbaric Oxygen Therapy	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional Requirements: • Special Medical Prior Authorization (SMPA) Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual

Service	Forms	Documentation
Hypnosis	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Hysterectomy	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional Requirements: • Sterilization Consent Form	• Current signed Physician Order • Current clinical documentation
Immunizations	• N/A	• N/A
Incontinence/Ostomy Supplies	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual For Service Provider changes: • Change of provider letter (Client Choice Statement) – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Infertility Services and Treatment	• Completed Medicaid Prior Authorization Request Form; or	• Current signed Physician Order • Current clinical documentation

Service	Forms	Documentation
	• TDI Standard Prior Authorization Request Form	
Injections	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Inpatient Hospital Facility Services (Acute)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Inpatient Rehabilitation – Freestanding (members 20 years of age and younger)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional requirements: • CCP Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation • Therapy goals related to client's individual needs and treatment plan
Intermediate Care Facility Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Lead Blood Screening	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation

Service	Forms	Documentation
Mammograms (Screening and Diagnostic)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Methadone	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current Physician Order signed by MD/DO • Complete current supporting clinical documentation
Nebulizers, Kits and Spacers (Supplies)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual For Service Provider changes: • Change of provider letter (Client Choice Statement) – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Newborn Care Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Nurse Midwife Services	• Completed Medicaid Prior Authorization Request Form; or	• Current signed Physician Order • Current clinical documentation

Service	Forms	Documentation
	• TDI Standard Prior Authorization Request Form	
Nursing Facility Services (Nursing Home Add-on services)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Nursing Services: See PDN and SNV section	• N/A	• N/A
Nutritional Assessment/Risk Reduction/Education	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
OB Ultrasound (Routine and High Risk)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Obesity Surgery (for Bariatric Surgery see Bariatric Surgery section)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Observation	• N/A	• N/A
Obstetrical Care Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation

Service	Forms	Documentation
Occupational Therapy	• Completed Therapy Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional requirements: • THSteps-CCP Prior Authorization Request Form • Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Request Form • Special Medical Prior Authorization (SMPA) Request Form	• Signed Physician Order or signed Prior Authorization Form or signed Plan of Care (cannot be older than 60 days from DOS), including frequency and duration Duration requirements: • Under 21 years of age: Request cannot exceed 180 days • Over 21 years of age: Request cannot exceed 60 days Current clinical documentation including: • Evaluation and Treatment Plan or Plan of Care (POC) with the required elements • Clinical documentation cannot be older than 60 days from requested DOS For Service Provider changes: • Change of provider letter (Client Choice Statement) – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements

Service	Forms	Documentation
Oncology Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Ophthalmology Services (Surgical and Non-Surgical)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Optometry (Medical Conditions of the Eye)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Orthopedic Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Orthotics	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual • For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.

Service	Forms	Documentation
Osteopathic Manipulation (Treatments)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Other Alternative Medical Therapies	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Out of State/ Country	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Outpatient Hospital Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Over-the-Counter (OTC) Drugs	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Oxygen and Related Respiratory Equipment	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual For Service Provider changes: • Change of provider letter (Client Choice Statement)

Service	Forms	Documentation
		– Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Pain Management	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation per Carelon Medical Benefits Management. guidelines/ Medical and/or Clinical Policies from the health plan For Service Provider changes: • Change of provider letter ("Client Choice Statement") – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Personal Care Services	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.

Service	Forms	Documentation
Personal Emergency Response	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.
Pest Control	• N/A	• For STAR+PLUS/ STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services and an unmet need must be identified on assessment by the LTSS team.
Physical Therapy	• Completed Therapy Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional requirements: • THSteps-CCP Prior Authorization Request Form • Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Request Form • Special Medical Prior Authorization (SMPA) Request Form	• Signed Physician Order or signed Prior Authorization Form or signed Plan of Care (cannot be older than 60 days from DOS), including frequency and duration Duration requirements: • Under 21 years of age: Request cannot exceed 180 days • Over 21 years of age: Request cannot exceed 60 days Current clinical documentation including: • Evaluation and Treatment Plan or Plan of Care (POC) with the required elements

Service	Forms	Documentation
		• Clinical documentation cannot be older than 60 days from requested DOS For Service Provider changes: • Change of provider letter (Client Choice Statement) – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirement
Physician Home Visits	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Podiatry Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Portable X-Ray Service	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Pre-Admission Testing	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation

Service	Forms	Documentation
Prescription Drugs – Self-Administered Drugs	• Completed Pharmacy Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form for Prescription Drug Benefits	• Current signed Physician Order • Current clinical documentation
Preventative Health Services – Adult	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Private Duty Nursing/Prescribed Pediatric Extended Care Center (PPECC) (age restriction birth-20 years of age)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional requirements: • THSteps- CCP Prior Authorization Request Form • Plan of Care Form • Nursing Addendum to Plan of Care for private duty nursing and/or PPECC	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual For Service Provider changes: • Change of provider letter (Client Choice Statement) – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements
Prostate-Specific Antigen (PSA) Testing	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation

Service	Forms	Documentation
Prosthetics	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual • For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.
Pulmonary Rehabilitation	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual
Radiation Therapy	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Radiology – Diagnostic	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Radiology – Nuclear Medicine	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation

Service	Forms	Documentation
Reconstructive Procedures	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Respiratory Therapy	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Respite Care Services in Assisted Living Facility (ALF), Nursing Facility (NF), Adult Foster Care (AFC), In Home	• N/A	• For STAR+PLUS/STAR Kids members requesting LTSS services, the member/legally authorized representative must request the services, and an unmet need must be identified on assessment by the LTSS team.
Second Opinions	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Skilled Nursing Facility (SNF)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Skilled Nursing Visits	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional requirements:	• Current signed Physician Order • Current clinical documentation as required per the Texas Medicaid Provider Procedures Manual

Service	Forms	Documentation
	• Plan of Care Form or Oasis Form • Special Medical Prior Authorization (SMPA) Request Form	
Sleep Studies and Sleep Therapy (Reviewed by Carelon Medical Benefits Management Inc.)	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Smoking Cessation Programs/Supplies	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Social Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation

Service	Forms	Documentation
Speech Therapy	• Completed Therapy Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional requirements: • THSteps-CCP Prior Authorization Request Form • Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Request Form • Special Medical Prior Authorization (SMPA) Request Form	• Signed Physician Order or signed Prior Authorization Form or signed Plan of Care (cannot be older than 60 days from DOS), including frequency and duration Duration requirements: • Under 21 years of age: Request cannot exceed 180 days • Over 21 years of age: Request cannot exceed 60 days Current clinical documentation, including: • Evaluation and Treatment Plan or Plan of Care (POC) with the required elements • Clinical documentation cannot be older than 60 days from requested DOS For Service Provider changes: • Change of provider letter (Client Choice Statement) – Client must sign/date letter, include name of previous and current providers, and effective date for the change – Refer to TMPPM requirements

Service	Forms	Documentation
Sterilization and Reversal	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form Additional requirements: • Sterilization Consent Form	• Current signed Physician Order • Current clinical documentation
Take Home Supplies	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Thermography/ Thermograms	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Signed Physician Order • Current clinical documentation
TMJ Treatment	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Transplant Donor	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Transplants	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation

Service	Forms	Documentation
Urgent Care Services	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation
Vision: • Optical Appliances (Lenses & Frames) • Routine Exams	• Reviewed by Superior Vision of Texas	
Weight Reduction Program	• Completed Medicaid Prior Authorization Request Form; or • TDI Standard Prior Authorization Request Form	• Current signed Physician Order • Current clinical documentation