

## TEXAS STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

### **Please read all instructions before completing the form.**

Do not send the completed form to the Texas Department of Insurance, the Texas Health and Human Services Commission, or to the patient's or subscriber's employer.

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standardized Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and the University of Texas and Texas A&M Systems.

**Intended use:** When an issuer requires prior authorization of a health care service, use this form to request the authorization **by fax or mail**. An issuer may also provide on its website an **electronic version of this form** that you can complete and submit to the issuer electronically, via the issuer's portal.

**Do not use this form:** 1) to request an appeal, 2) to confirm eligibility, 3) to verify coverage, 4) to ask whether a service requires prior authorization, 5) to request prior authorization of a prescription drug, or 6) to request a referral to an out of network physician, facility or other health care provider.

### **Additional information and instructions:**

Section I. An issuer may have already prepopulated its contact information on the copy of this form posted on its website.

Section II. Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review, to prevent a serious deterioration of the patient's condition or health.

### Section IV.

- If the *Requesting Provider or Facility* will also be the *Service Provider or Facility*, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

### Section VI.

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, radiology studies, etc.), if needed.

**Note:** Some issuers may require more information or additional forms to process your request. If you think an additional form may be needed, please check the issuer's website before faxing or mailing your request.

If the requesting provider wants to be called directly about missing information that the issuer must have to process this request, and the provider's direct phone number is not the contact phone number listed in Section IV, enter the provider's direct phone number in the space given at the bottom of the request form. *This call is intended only to ensure that the issuer receives the information it needs to review the request. It is **not** a peer-to-peer discussion afforded by a utilization review agent (URA) before issuing an adverse determination, as required by 28 TAC §19.1710.*