Home Health Services (Title XIX) 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.

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 Agreement requirements as stated in the relevant Texas Medicaid Provider Procedures Manual and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

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Section A: Requested Durable Medical Equipment and Supplies

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

Client Information

Client Name:	Medicaid number:	Date of birth:

Supplier Information

Name:	Telephone:	Fax number:
Address:		

TPI:	NPI:	Taxonomy:	Benefit Code:
QRP name:		QRP TPI:	QRP NPI:

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):	

Prescribing Physician Information

Name:	Telephone:	Fax number:

Item Number	HCPCS Code	Description of DME/medical supplies	Qty.	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

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

Section B: Diagnosis and Medical Need Information

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

Item Number[2] (From Section A)	Diagnosis	Brief Diagnosis Descriptor	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. A range of item numbers may be entered.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status:

***Note**: The "Date last seen" and "Duration of need" items 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 in Section "A", with the exception of the DME provider's signature, was complete at the time of my signature and 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 TPI:	NPI:	License number:

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 Information

Client Name:	Medicaid number:	Date of birth:

Supplier Information

Name:	Telephone:	Fax number:
Address:		

TPI:	NPI:	Taxonomy:	Benefit Code:
QRP name:	QRP TPI:	QRP NPI:	

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):

Prescribing Physician Information

Name:	Telephone:	Fax number:

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

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

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 in Section "A", with the exception of the DME provider's signature, was complete at the time of my signature and 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 TPI:	NPI:	License number: