



Non-emergency Ambulance Exception

Submit completed form by fax to: 1-512-514-4205

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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Requesting Provider Information

Provider Name: Date Request Submitted:
TPI: NPI: Taxonomy:
Contact Name: Phone: Fax:
Ambulance Provider: Ambulance Provider Identifier:

Client Information

Client Name (Last, First, MI):
Date of Birth: Client Medicaid/CSHCN Number:
Functional, physical or mental health debilitating condition affecting transport:

Request Type

By checking the boxes below and signing this form:
I attest that the client has a permanent debilitating condition...
Additional information:
I attest that the client has a debilitating condition...
Additional information:

Documentation

The following attachments must be submitted with the request:
1. Nonemergency Ambulance Prior Authorization Request
2. Documentation supporting client's debilitating condition...
NOTE: Documentation submitted with statements "client 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.

Name: Title: Provider Identifier:
Signature: Date Signed:



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Provider Instructions for Non-emergency Ambulance Exception

This form must be completed by the provider requesting a non-emergency ambulance exception. All non-emergency ambulance exception requests must have the physician document that the client 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. (i.e., 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 ten-digit number issued by the National Plan and Provider Enumeration System (NPPES).
 - Enter the primary national taxonomy code. This is a ten-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. At a later date, if the ambulance provider changes from the provider you originally requested, notify TMHP of the new provider by phone (1-800-540-0694, Option 3) or fax (1-512-514-4205).
5. **Client Information**— This section must be filled out to indicate the client’s name in the proper order (last, first, middle initial). Enter the client’s date of birth and client number.
6. **Request Type**—Check the box for the request type. In the first box the physician is attesting that the client has a permanent debilitating condition. In the second box the physician is attesting that the client has a debilitating condition which is expected to last for a continuous period of no less than 12 months. The physician may provide additional information if needed.
7. **Documentation**—The provider must submit the completed Nonemergency Ambulance Exception form, the Nonemergency Ambulance Prior Authorization Request form and documentation supporting client’s debilitating condition.(i.e. surgical report, summary of history, physical therapy evaluation summary)
8. **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 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.