Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions

General Instructions

This form must be completed and signed as outlined in the instructions below before DME/medical supplies providers contact TMHP Home Health Services for prior authorization. Fax completed form to (512)514-4209.

Either the DME supplier/Medicaid provider or the prescribing physician may initiate the form. This completed form must be retained in the records of both the DME supplier/medical provider and the prescribing physician, and is subject to retrospective review. This form becomes a prescription when the physician has signed section B. With the exception of the DME provider's signature, this form may not be altered or amended once it is signed by the prescribing physician.

Note: *This form cannot be accepted beyond 90 days from the date of the prescribing physician's signature.*

All fields must be filled out completely. The prescribing physician's TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Section A: Requested Durable Medical Equipment and Supplies

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer's suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

For wheeled mobility systems or major modifications to a wheeled mobility system, the supplier or Qualified Rehabilitation Professional (QRP) must complete the QRP name, QRP TPI, and QRP NPI fields.

Requested Durable Medical Equipment and Supplies

Item number	HCPCS Code	Description of DME/medical supplies	Quantity	Price
1	J-E1399	Appropriate HCPCS code description	1	$50.00
2	J-E1220	Appropriate HCPCS code description	1	$2500.00
3				
4				

Examples of Supplies

Item number	HCPCS Code	Description of DME/medical supplies	Quantity	Price
1	9-A4253	Appropriate HCPCS code description	2 boxes	N/A
2	9-A4259	Appropriate HCPCS code description	1 box	N/A
3	9-A4245	Appropriate HCPCS code description	1 box	N/A
4				

The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must be used when prescribing more than 4 items. The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must accompany *the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form*.

Note: *Addendums received without this form will not be accepted.*

Reminder: *Home health services are not a benefit for clients residing in a nursing facility, hospital, or intermediate care facility.*

Note for DME: *The DME company must also complete the DME Certification and Receipt Form. All equipment is to be assembled, installed, and used pursuant to the manufacturer's instructions and warning.*

Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions

Section B: Diagnosis and Medical Information

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

The prescribing physician must indicate the corresponding item number requested from Section A, appropriate diagnosis code with a brief description, and complete justification for determination of medical necessity for the requested item(s). If applicable, include height/weight, wound stage/dimensions and functional/mobility.

The physician is not required to repeat the procedure code or description of the requested DME or supplies in this section.

Note: *The date last seen must be within the past 12 months.*

The prescribing physician must indicate the duration of need for the prescribed supplies/DME. The estimated duration of need should specify the amount of time the supplies/DME will be needed, such as six weeks, three months, lifetime, etc. The prescribing physician's TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Note: *Signatures from nurse practitioners, physician assistants, and chiropractors will not be accepted. Signature stamps and date stamps are not acceptable.*

Diagnoses:

Providers must use an appropriate diagnosis code for all prior authorization requests.

Item No. [2] (From Section A)	**Diagnosis**	**Brief Diagnosis Description**	**Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.**[1,2]
1,2	16901	Appropriate diagnosis description	Unable to get in and out of the tub or shower.
2	E6601	Appropriate diagnosis description	Need swing-away arms and legs for transfer secondary to hemiparesis and need oversize chair for clients weighing 400 lbs.

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

Examples of Supplies

Item No. [2] (From Section A)	**Diagnosis**	**Brief Diagnosis Description**	**Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.**[1,2]
1,2,3	E109	Appropriate diagnosis description	Client has frequent variation of blood glucose levels and needs monitoring several times a day.

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

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

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.

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:

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.

Section A: Requested Durable Medical Equipment and Supplies

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

Client Information

Client Name: John Doe	Medicaid number: 1234567	Date of birth: 06/ 08 / 1987

Supplier Information

Name: Prentke Romich Company	Telephone: 800-262-1984	Fax number: 330-263-4829

Address: 1022 Heyl Road Wooster, OH 44691

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: Dr. Awesome	Telephone: 111-222-3333	Fax number: 111-222-3333

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?	Beyond quantity limit?[1]	Custom item?[1]
1	E2510	Accent 1000	1	$7295	□ Y □ N	□ Y □ N	□ Y □ N
2	E2599	Keyguard - 84	1	$145	□ 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)
1	111.22	Write diagnosis here	necessary for communication
2	111.22	Write diagnosis here	necessary for accuracy in access

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: 60 month (s)	Duration of need for supplies: 60 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's license number:

Prescribing physician's TPI:	Prescribing physician's NPI: