Amerigroup

Medicaid

Special Medical Prior Authorization (SMPA) Request Form

Please fax to applicable department for the requested service:

- Physical Health: **800-964-3627**
- Behavioral Health: **844-442-8010**
- Pharmacy: **844-474-3341**

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),* Amerigroup provider manual, and your provider agreement.

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 requirements as stated in the relevant Amerigroup provider manual and *TMPPM* and they agree and consent to the Certification above.

☐ We Agree

Section A: Member information		
Name:		
Medicaid number:		Date of birth:
Subscriber ID:		
Section B: Requested procedure or service information		
Type of request: ☐ Transplant ☐ Surgery ☐ EKG ☐ Other:		
Expected dates of service From: To:		
Procedure requested CPT® code	**Procedure code description**	
Comments:		
Section C: To be completed by requesting physician or prescribing provider (Additional information may be attached.)		
Diagnosis codes:		
Statement of medical necessity (refer to the appropriate section of the *TMPPM* for specific prior authorization requirements):		
Physician's name:		
Address/City/ZIP:		
Telephone number:		Fax number:
TIN:	NPI:	Taxonomy:
Physician's signature:		Date signed:
Section D: Service provider or facility information — If different from provider in Section C		
Provider printed name:		
Contact person:		Date:
Address/City/ZIP:		
Telephone number:		Fax number:
TIN:	NPI:	Taxonomy: