

INSTRUCTIONS FOR PRIOR AUTHORIZATION REQUEST FORM

A Prior Authorization Request (PAR) form is required for TB patients for provider or vendor services that are paid for by the Central Office TB Program. The PAR must be authorization by the Central Office (CO). If services are to be continued past the end date, it will require a new PAR sent, prior to the end of the authorization date of the original, to Central Office staff for authorization. Prior Authorizations Requests are to be sent in prior to the service or billing. Do not wait for bills to come in to send a PAR to CO.

Services (not an all-inclusive list) that require prior authorization request by the State TB Control Officer or his designee:

- Hospital admission, including out-of-state facilities (as long as the patient is not hospitalized from a jail/prison while being held for criminal charges)
- Chest x-rays performed by private providers, this includes CXR on pediatrics at hospitals
- Bronchoscopes with and without Biopsies
- Housing - hotel/motel, rent, long-term care (or other facility) admission, etc.
- CT scans
- Specialty consults
- Specialty procedures (PEG tube inserted), etc., gastric aspirate
- Security guard services
- Others services that you question if it could be paid - please check with Central Office

Emergent or urgent services should never be delayed to obtain prior authorization request. However, the Central Office TB Program should be notified at the earliest time if urgent/emergent services are requested for a TB patient. An extra sheet may be attached if additional explanation is needed.

Instructions for Obtaining Prior Authorization for TB Services

Note: Words in italics match headings on the form.

A *Request for Prior Authorization Form* should be submitted in writing using the attached work sheet. This form should be completed in its entirety and faxed or e-mailed to the Central Office TB Program as noted below.

1. Complete all parts of the form. Print or write legibly.
2. Enter the name of the Person Completing and Submitting Form in the *Completed by* section.
3. The *Date Submitted* - the date you complete and send the form.
4. The *Direct Phone Number* is the number of the person completing the form.
5. Enter the *Region* and *County* the patient lives in.
6. Enter *Patient Name* - as Last Name, First Name and Middle Name.
7. Enter *Date of Birth (DOB)*.
8. *Gender* - Male or Female.
9. *Address - Street, City, State* and *Zip Code* where patient currently resides
10. *Homeless* check yes or no.
11. Verify if *Insured* applies: commercial — list the company, Veterans Benefits, Medicare or Medicaid, TennCare – List Company, if it is still pending fill in *Date Filed* and *Place (hospital or DHS office, etc.)*. TTBEF is payor of last resort; other insurance must be filed first.

12. *Type of Service Requested* - check the type of service requested. For non-medical services list the cost of the service. For rent/mortgage or utilities use the monthly rate (use the last month for the utilities).
13. *Proposed Service Provider - Name of Provider/Facility/Vendor* to provide services, *Address (street, City, State, Zip)*. *Contact Person* with their complete *Phone and Fax number and email address*. We must have this to send the appropriate paper work so payment can be made.
14. *Service Request Information - Proposed Date of Service* may be approximate dates (one date or a range of requested dates, i.e. - for hospitalization). Notify Central Office when you have an exact date of service. If it is a one-day event then put same date in the *From* and *To* date boxes. If it is for a hospital stay the *From* day is the date the health dept. was notified of the suspect, not the date they entered the hospital. It is the hospital's responsibility to notify you of the suspect. We do not pay for hospital stays that we were unaware of the patient. The *To* date will be two weeks from the *From* date for hospital stays.
15. *Date of discharge* - from hospital or another facility. Notify the CO if the patient is discharged during the PAR dates.
16. *Justification for Services Requested and Clinical Indications* – write a brief statement. **Attach all supporting documentation.**
17. Fax the form and supporting documentation to TB Fax machine at 615-253-1370 or email to Sharon J. Thompson, R.N., PHNC2 @ Sharon.J.Thompson@tn.gov or 615-532-8517, Teresa Vantrease, RN., PHNC2 @ Teresa.Vantrease@th.gov, 615-741-5885 or Sheila F. Allen, RN., PHNC 2@ Sheila.Allen@tn.gov or 615-532-5762. **If you have any questions, please contact one of the nurse consultants.**
18. The PAR will be reviewed by the TB Control Officer or his designee and will indicate if *approved*, *modified* or *not approved*.
19. Central Office Physician/Staff will sign and date the form. The form will be returned to the Metro/Region. Please note if the form was *approved*, *modified* (see comments) or *denied*.

Instructions of other responsibilities for the Regional/Metro staff:

1. If the P.A.R is for medical services, provide the vendor with a copy of the signed PAR form including the 2nd page to ensure that the vendor understands the terms and their responsibility for billing, to receive payment and that the patient cannot be billed directly. If the P.A.R. is for rent/housing/utilities, provide the vendor only with page 2 of the form to ensure that the vendor understands the terms and their responsibility for billing, to receive payment and that the patient cannot be billed directly.
2. If a PAR is not for medical services, discuss with the vendor, prior to submitting the PAR) if they are willing to accept the terms of the prior authorization, and that payment may take 45 – 60 days after all documentation is received in to Central Office. They will have to furnish a W-9 form if not already a vendor in Edison. CO will prepare and send the Authorization to Vendor (ATV) form after we receive the bill/invoice. It must be signed in **Blue** ink and the original form mailed to the address on the PAR form or if a color scanner is available it can be scanned and emailed back to CO.
3. Ensure that the provider is aware of the provision that they are agreeing to accept the State payment as “payment in full”. Under no circumstance, including but not limited to non-payment by the State for non-approved services, shall a vendor bill, charge, or seek compensation, remuneration or reimbursement from or have any recourse against any patient. The patient should also be aware of this provision in order to notify the vendor if he/she receives an invoice.