PRIOR AUTHORIZATION REQUEST

Completed by: **Date Submitted to TTBEP C.O.:** _____/_____/_____

Direct Phone Number: ( ) - **Region:** **County:**

PATIENT DATA

Patient Name: (Last, First, MI)	**Date of Birth:** / /	**Gender:** ☐ Male ☐ Female
Address: (Street, City, State, Zip)		**Homeless:** ☐ Yes ☐ No

Insured? ☐ **Yes** (specify below) ☐ **No** (skip to next section)

Insurance Type: ☐ Commercial – Company Name: _____

☐ Medicare: #_____ ☐ Medicaid: Medicare: #_____

☐TennCare: #_____ ☐ Veterans Benefits: _____

☐ Pending Application – Date Filed: ____ /____/____ Place: _____

TYPE of SERVICE REQUESTED

☐ **Inpatient Admission:**

- ☐ Hospital
- ☐ Long-term Care
- ☐ Other: _____

Note: *Total length of stay* *cannot* *exceed 14 days per prior approval request.*

☐ **Outpatient Hospital/ Other Medical Services:**

- ☐ Diagnostic
- ☐ Durable Medical Equipment
- ☐ Radiology/ Imaging
- ☐ Home Health/ Home Infusion
- ☐ Therapy (PT/ OT/ ST)
- ☐ Surgical : _____
- ☐ Other: _____

☐ **Non-medical Services:**

- ☐ Rent/ Mortgage: $_____Per_____
- ☐ Utilities: $_____Per_____
- ☐ Lodging/ Motel: $_____Per_____
- ☐ Transportation: $_____Per_____
- ☐ Other: _____ _____ $_____Per_____

PROPOSED SERVICE PROVIDER

Name of Provider / Facility / Vendor:	**Contact Person:**
Physical Address: (Street, City, State, Zip)	**Phone Number:** ( ) -
Mailing Address: (P.O. Box or Street, City, State, Zip)	**FAX Number:** ( ) - **E-mail:** _____

SERVICE REQUEST INFORMATION

Proposed Service Date(s) – From: / / **To:** / / **Date of discharge:** / /

Justification For Requested Services (Fax all supporting documents with Prior Authorization Request Form)**:**

CENTRAL OFFICE USE ONLY:

Medical Director Review: ☐ **APPROVED** ☐ **MODIFIED** ☐ **DENIED**

Comments:

Medical Director Signature: **Date:** / /

Tennessee Department of Health, TB Elimination Program
710 James Robertson Pkwy., 3rd Floor, Andrew Johnson Tower, Nashville, TN 37243
Phone: 615-253-2308 / Fax: 615-253-1370

Service Provider: Please see important claims information on Page 2.

IMPORTANT CLAIMS PAYMENT INFORMATION

1. **The State is not responsible for the payment of services rendered without specific, written authorization**.

2. The Vendor/provider will submit an invoice in form and substance acceptable to the State to effect payment. Accordingly, hospitals should bill on an original UB-04CMS 1450 Form, and other medical/clinical service providers should bill using an original CMS-1500 Form. Non-medical service providers/vendors should submit a pre-numbered invoice that indicates date of invoice, description of goods or services, unit price, and total amount. **All invoices for services rendered shall be submitted to the State within one hundred twenty (120) days of service delivery except in situations when provider is pursuing payment from a Third Party Payer, in which case the filing limit will be ninety (90) days from the Third Party Payer's processing date stated on the explanation of benefits (EOB). Notwithstanding, the State shall not reimburse any invoices submitted later than one hundred eighty (180) days after the end date of the Authorization to Vendor (the "Settlement Period").** However, the filing limit is extended another ninety (90) days if the services were provided during the last three (3) months of the State Fiscal Year. Vendor expressly agrees to waive any fees for services rendered that have not been invoiced to the State prior to the end of the Settlement Period.

3. The Vendor acknowledges that the State of Tennessee is the "Payor of Last Resort" when the patient is covered by a Third Party Insurance, private or public. If the patient has no insurance, or if certain services are not covered by the Third Party Insurance, or access to the patient's insurance has been denied, the claims may be paid by the State as outlined below:

   a. If payments from other sources equal or exceed the amount of the State's maximum liability as a sole payor, the State shall not pay additional fees on any charge. Notwithstanding, the State may reimburse for prior-approved services that exceed the Third Party Insurance reimbursement amount, up to the maximum allowed by the State.

   b. In billing the State, the vendor shall include the amount paid by the Third Party Insurance (Explanation of Benefits - EOB) along with the total invoice/claim amount. The State shall pay the difference between these sums as long as the combined amount of payment by the Third Party Insurance and the State does not exceed the State maximum rate.

   c. In regard to deductibles and co-pays, the State shall be responsible for reimbursement to the Vendor in an amount of either the State's maximum or the vendor's invoice/claim amount, whichever is less.

   d. Payment by the State shall be considered "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.

4. In the event that the State is the primary payor (payor of last resort), payment rates for professional/outpatient hospital services shall be based on one (1) of the following methods: Medicare Fee Schedules; State Maximum Rates; or, when there are no other established rates, on a negotiated cost basis. **Inpatient hospital services are reimbursed at 70% of covered/allowable charges as determined by review and analysis of itemized statements and/or medical records.** Non-medical services are paid on a negotiated cost basis.

5. All medical claims for in-patient hospital services will be reviewed for medical necessity and appropriateness to determine services that meet the criteria for payment. Therefore, vendors/providers are required to submit itemized statements along with the UB-04 for all in-patient hospital services.

6. Unless they are already established in "EDISON" (i.e., the Enterprise Resource Planning (ERP) system of the State of Tennessee), vendors will be required to submit a substitute W-9 form in order to set up a vendor account.

7. **In order to be paid, all vendors/providers are required to submit a signed "AUTHORIZATION TO VENDOR FORM (ATV)". The ATV must always be signed in BLUE ink; and the signed original mailed to the address on Page 1.** The ATV will be sent to the vendor/provider shortly after a claim/invoice is submitted that can be processed without requiring additional information from the provider/vendor or from a third party ("clean claim"). **The vendor/provider is required to return the signed ATV within 21 business days of receipt.**

8. If the vendor/provider fails to return the signed ATV as requested, the State will send the first reminder giving the vendor/provider ten (10) business days to submit the signed ATV.

9. If once again the vendor /provider fails to return the signed ATV after receiving the first reminder, the State will send a second reminder giving the vendor/provider five (5) business days to submit the signed ATV. Failure to submit the signed ATV after receiving the second reminder will result in forfeiture of rights for payment and the vendor/provider may not seek payment from the patient.

10. All Clean Claims will be paid within thirty (30) days from the date the duly-signed ATV is received.