Wellpoint Nonemergency Ambulance Exception Prior Authorization Request

Texas | Medicaid

For **behavioral health**/intellectual and developmental disabilities services, fax to: **844-442-8010**

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

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

☐We Agree

Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

Requesting provider information		
Requesting provider name:*		
Requesting provider NPI:*		Date request submitted:
Contact name:	Telephone:	Fax:
Rendering provider information		
Rendering ambulance provider:*		Ambulance NPI:*
Tax ID:*	Benefit code:*	Taxonomy:*
Street address:*		
City:	State:	ZIP + 4:*
Contact name:	Telephone:	Fax:
Member information		
Member name (*Last, First, MI*):*		
Member Medicaid ID number:*		Date of birth:*
Functional, physical, or mental health debilitating condition affecting transport:		
Diagnosis code(s):*		

Requested services	
HCPCS procedure code:*	Brief description of services:

Request type

By checking the boxes below and signing this form:

☐ I attest that the member has a permanent debilitating condition resulting in the physical or mental inability to perform activities for the remainder of his/her life. For this condition, I am requesting a 180-day prior authorization request.
Additional information:

☐ I attest that the member has a debilitating condition resulting in a physical or mental inability to perform activities that can be expected to last for a continuous period of **no less than 12 months**. For this condition, I am requesting a 180-day prior authorization request.
Additional information:

Documentation

The following attachments must be submitted with the request:

1. *Nonemergency Ambulance Prior Authorization Request*
2. Documentation supporting member's debilitating condition such as, but not limited to:
   - Discharge summary
   - Diagnostic image(s) interpretation report(s) (in other words, MRI, CT, X-rays)
   - Care Plan

Note: *Documentation submitted with statements reading "member has a debilitating condition" is insufficient.*

Certification

I certify the information supplied in this document is true, accurate, complete, 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. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law, which can result in fines or imprisonment in addition to recoupment of funds paid and administrative sanctions authorized by law.

Requesting physician's printed name:*

Requesting physician's NPI:*

Requesting physician's signature: Date signed:

Provider Instructions for Nonemergency Ambulance Exception

Texas | Medicaid

This form must be completed by the provider requesting a nonemergency ambulance exception. All nonemergency ambulance exception requests must have the physician document that the member has a debilitating condition and require recurring trips that will extend longer than 60 days:

- **Requesting provider information** — Enter the name of the entity requesting authorization (for example, hospital, nursing facility, dialysis facility, physician).
- **Request date** — Enter the date the form is submitted.
- **Requesting provider identifiers** — Enter the following information for the requesting provider (facility or physician):
  - Enter the requesting provider's name.
  - Enter the National Provider Identifier (NPI) number. An NPI is a 10-digit number issued by the National Plan and Provider Enumeration System (NPPES).
- **Ambulance provider identifiers** — Enter the following information for the rendering ambulance provider:
  - Enter the rendering ambulance provider's name.
  - Enter the rendering ambulance provider's NPI.
  - Enter the rendering ambulance provider's tax ID.
  - Enter the rendering ambulance provider's benefit code.
  - Enter the requested ambulance provider's primary national taxonomy code. This is a 10-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at **wpc-edi.com**.
  - Enter the requested ambulance provider's address.
- **Member information** — This section must be filled out to indicate the member's name in the proper order (last, first, middle initial). Enter the member's date of birth and Medicaid ID number.
- **Requested services** — Enter the requested Healthcare Common Procedure Coding System (HCPCS) procedure code and a brief description of the requested services. The applicable codes are listed below:

Procedure codes				
A0382	A0398	A0422	A0424	A0425
A0426	A0428	A0430	A0431	A0433
A0434	A0435	A0436	A0999	

- **Request type** — Check the box for the request type. In the first box, the physician is attesting that the member has a permanent debilitating condition. In the second box, the physician is attesting that the member 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.
- **Documentation** — The provider must submit the completed *Nonemergency Ambulance Exception* form, the *Nonemergency Ambulance Prior Authorization Request* form and documentation supporting the member's debilitating condition (for example, surgical report, summary of history, physical therapy evaluation summary).
- **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, NPI number provided and the 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.