CSHCN Services Program Home Health (Skilled Nursing) Referral and Treatment Plan Form and Instructions

General Information

- Ensure the most recent version of the Home Health (Skilled Nursing) Referral and Treatment Plan is submitted. The form is available on the TMHP website at www.tmhp.com.
- **Complete all sections of this form.**
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-512-514-3000, option 2, or 1-800-568-2413, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for assistance with this form.
- This form may be submitted by mail to the following address:

  TMHP-CSHCN Services Program Authorization Department
  12357-B Riata Trace Parkway Ste #100 MC-A11
  Austin, TX 78727
- This form may be submitted by fax to 1-512-514-4222.
- Submit only the referral and treatment plan form. Do not submit instruction pages.
- Refer to: Chapter 22, "Home Health (Skilled Nursing) Care."

Client Information

Field Description	Guidelines
First name	Enter the client's first name as indicated on the CSHCN Services Program eligibility form
Last name	Enter the client's last name as indicated on the CSHCN Services Program eligibility form
CSHCN Services Program number	Enter the client's ID number as indicated on the CSHCN Services Program eligibility form
Date of birth	Enter the client's date of birth as indicated on the CSHCN Services Program eligibility form
Address/City/State/ZIP	Enter the client's address, city, state, and ZIP
Diagnosis	Enter the diagnosis code relevant to the client's condition.

Requested Services

Field Description	Guidelines
Start of care date (mm/dd/yy)	Indicate the start of care date
End of care date (mm/dd/yy)	Indicate the end of care date
Request status	Indicate the request status (new, extension or revision)
Type of service	Indicate the required skilled nursing (registered nurse [RN] or licensed vocational nurse [LVN]) services requested. Include hours per day, days per week and number of weeks including totals.
Additional comments	Indicate any additional information that is relevant to this request.

If hours from a previous authorization were not used, complete the following:

Field Description	Guidelines
Service dates affected	Enter the affected service dates
Original number of hours requested for the service dates	Enter the original number of hours requested for the service dates

Field Description	Guidelines
Actual number of hours used for these service dates	Enter the actual number of hours used for the service dates
Reason hours were not used	Enter the reason hours were not used
RN/LVN name	Enter the RN or LVN's name
RN/LVN signature	RN or LVN must sign in this field
Date	Enter the date the form was signed
Telephone number	Enter the RN or LVN's telephone number

Provider Information and Required Signature

Field Description	Guidelines
Provider name	Enter the provider's name
CSHCN TPI	Enter the provider's Texas provider identifier (TPI)
NPI	Enter the provider's national provider identifier (NPI)
Taxonomy code	Enter the provider's taxonomy code
Benefit code	Enter CSN
Provider contact name	Enter the provider's contact name
Telephone number	Enter the provider's telephone number
Fax number	Enter the provider's fax number
Address/City/State/ZIP	Enter the provider's address, city, state, and ZIP
Provider signature	Provider must sign in this field
Date	Enter the date the form is signed

Physician Information and Required Signature

Field Description	Guidelines
Recent health history	Indicate client's recent health history
Brief statement of medical necessity for in-home skilled nursing services	Enter a brief statement of medical necessity for in-home skilled nursing services
Treatments ordered	Enter the treatments ordered
Medications (primary)	Indicate the primary medications
Nutritional requirements	Indicate the nutritional requirements
Safety of precautionary measures	Indicate the safety of precautionary measures
Developmental/functional status	Indicate the client's developmental and functional status
Prognosis	Indicate the client's prognosis
Date last seen	Enter the date the client was last seen
Progress summary	Enter the progress notes
Physician name	Enter the provider's name
Telephone number	Enter the provider's telephone number
Physician signature	Physician must sign in this field
Date	Enter the date the form is signed

CSHCN Services Program Home Health (Skilled Nursing) Referral and Treatment Plan (page 1 of 2)

Client Information:

First name:	Last name:
CSHCN Services Program number: 9--00	Date of birth:
Address/City/State/ZIP:	
Diagnosis:	

Requested Services:

Start of care date (mm/dd/yy):		End of care date (mm/dd/yy):	
Request status:	☐ New	☐ Extension	☐ Revision

Type of Service	Hours/Day	x Days/Week	x Number of Weeks =	Total Hours
Skilled nursing (RN) hours				
Skilled nursing (LVN) hours				
Sum of total hours requested:				

Additional comments:

If hours from a previous authorization were not used, complete the following:

Service dates affected:	
Original number of hours requested for the service dates:	
Actual number of hours used for these service dates:	
Reason hours were not used:	
RN/LVN name:	RN/LVN signature:
Date:	Telephone number:

Provider Information and Required Signature:

Provider name:	Other contact name (if any):
CSHCN TPI:	NPI:
Taxonomy code:	Benefit code: **CSN**
Telephone number:	Fax number:
Address/City/State/ZIP:	
Provider signature:	Date:

CSHCN Services Program Home Health (Skilled Nursing) Referral and Treatment Plan (page 2 of 2)

Client Information:	
First name:	Last name:
CSHCN Services Program number: 9-_____-00	
Physician Information and Required Signature: **The following information must be completed by a physician.**	
Recent health history:	
Brief statement of medical necessity for in-home skilled nursing services:	
Treatments ordered:	
Medications (primary):	
Nutritional requirements:	
Safety of precautionary measures:	
Developmental/functional status:	
Prognosis:	
Date last seen:	
Progress summary:	
I conclude that the client named above requires care as requested on this referral and treatment plan for home health (skilled nursing) services.	
Physician Name (typed or printed):	Telephone number:
Physician signature:	Date: