Special Medical Prior Authorization (SMPA) Request Form

Use only for requests submitted to the TMHP-SMPA department. Mail completed form to the TMHP Special Medical Prior Authorization at 12357-B Riata Trace Parkway Ste. 100, Austin, TX 78727 or fax to 1-512-514-4213.

Section A: Client information	
Name:	
Medicaid number:	Date of birth:

Section B: Requested procedure or service information	
Type of request: ☐ Transplant ☐ Surgery ☐ECG ☐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		
Diagnoses (ICD-9-CM):		
Statement of medical necessity (Refer to the appropriate section of the Texas Medicaid Provider Procedures Manual for specific prior authorization requirements):		
Physician's name:		
Address/City/ZIP:		
Telephone number:	Fax number:	
TPI:	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:	
TPI:	NPI:	Taxonomy: