Authorization Request for
Initial Outpatient Therapy (TP1)

Complete the following form and submit to the TMHP-CSHCN Authorization Department at 12357-B Riata Trace Parkway MC-A11, Austin, TX 78727 or fax to 1-512-514-4222.
For help completing this form, call TMHP-CSHCN Customer Service at 1-800-568-2413.
Note: This form is only for INITIAL authorization of physical, occupational, or speech-language therapy. Use the TP2 form to request an extension of therapy services.
Please print or type requested information below.

Client Information

First Name:	Last Name:	CSHCN number: 9-_____-00
Date of Birth:	Diagnosis (ICD-9-CM):	
Address/City/Zip		

Evaluation Summary:

Has the child received therapy in the last year from the public school system? If yes, a copy of the child's Individualized Education Program (IEP) *must* be attached.	☐ Yes	☐ No

Date of Evaluation: (A copy of the initial evaluation must be attached.)

Type of evaluation: ☐ Physical Therapy (PT) ☐ Occupational Therapy (OT) ☐ Speech Language Pathology (SLP)

Comments:

Service Request:

Indicate procedure code(s), type of service (PT, OT, or SLP), the dates of service, and the frequency per week or month.
Dates of service cannot exceed six months. If possible, end requested date(s) of service on the last day of a month.

Procedure Code	TOS	From Date	To Date	Frequency/Week	Frequency/Month

Physician Name:	Physician Signature:	Date:
PT Name:	PT Signature:	Date:
OT Name:	OT Signature:	Date:
SLP Name:	SLP Signature:	Date:

Provider Required Signature and Information:

Provider name:	CSHCN TPI number:
Provider contact name:	5-digit local number:
Telephone number:	Fax number:
Address/City/Zip:	
Signature of service provider:	Date: