BlueCross BlueShield of Texas

TEXAS STAR Kids Your Health Plan ★ Your Choice | TEXAS Health and Human Services

LTSS Authorization Request
Phone: 1-877-301-4394
Fax: 1-866-644-5456

Date Request Submitted:			
Member Name:			
Address:		City	
State:	ZIP Code:	Phone:	
Person completing Form:		Phone:	Fax:

Service Type: ☐ Agency ☐ CDS ☐ SRO

	New Request?	Current Service?	
☐ Personal Care Services	☐	☐	Hours/Week:_____
☐ Private Duty Nursing	☐	☐	Hours/Week:_____
☐ PAS/Habilitation	☐	☐	Hours/Week:_____
☐ Day Activity and Health Services (DAHS)	☐	☐	Hours/Week:_____
☐ PPECC	☐	☐	Hours/Week:_____
☐ Respite	☐	☐	Hours/Week:_____
☐ Supported Employment	☐	☐	Hours/Week:_____
☐ Employment Assistance	☐	☐	Hours/Week:_____
☐ Flexible Family Support Service	☐	☐	Hours/Week:_____
☐ ERS	☐	☐	Months: ____
☐ Adaptive Aids	☐	☐	$_____
☐ Minor Home Mods	☐	☐	$_____
☐ Transition Assistance Service	☐	☐	$_____

Date of Service: Begin Date:_____ End Date: _____

Provider NPI/API: _____ **Agency Name**:_____

Justification for Request (Diagnosis Code Required):_____

Certain request for services require specific clinical information for us to authorize requested services. Always include this information with the Request for LTSS Authorization Form. If there's no form available for the service you are requesting authorization for, please submit information from your own files that would support the request. Thank you.

Health Plan Use Only

Status

Approved: _____ Expires: _____ Authorization Number: _____

Comments: _____

Representative Name Nurse Reviewer: _____

This authorization is based on medical necessity only and will be contingent upon eligibility and benefits. This is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. Please call the number at the top of this form if this member has any additional medical or behavioral health needs.