**To: TMHP Prior Authorization** **Date: __________**
**Fax- 512-514-4209**

**From: Name:____________________________**

**Address:__________________________**

**City,St,Zip:________________________**

**Phone:____________________________**

**Re: Child's Name:________________________ Medicaid #________________**

**Dear Sir/Mam,**

**Christ Centered Medical Supplies 013361301/091496201 is our new DME provider. Their phone number is 903-796-5378. Please release any prior authorizations from ____________________________________________________________________________ on only the items listed on the attached physician orders so that Christ Centered may get approval to send our supplies effective as dated above. If there are other items not on the attached physician orders that have existing authorizations with other providers then leave those items authorized as listed.**

**Thank You,**

**Signature:________________________**

**Relationship:______________________**