ForwardHealth
Wisconsin serving you

Update
June 2008

No. 2008-54

**Affected Programs:** BadgerCare Plus, Medicaid
**To:** Counties Certified for Outpatient Mental Health/Substance Abuse Services in the Home or Community, County Mental Health Coordinators, Federally Qualified Health Centers, Master's-Level Psychotherapists, Mental Health/Substance Abuse Clinics, Outpatient Hospital Providers, Psychiatrists, Psychologists, Tribal Human Service Facilitators, HMOs and Other Managed Care Programs

# Changes to Prior Authorization for the Outpatient Mental Health Benefit

This *ForwardHealth Update* introduces important changes to prior authorization (PA) for the outpatient mental health benefit, effective October 2008, with the implementation of the ForwardHealth interChange system. These changes include the following:

- Establishing deadlines for providers to respond to returned PA requests and PA amendment requests.
- Revising all PA forms. The following PA forms will be available to download and print from the Web at *dhfs.wisconsin.gov/ForwardHealth/*:
  - ✓ Prior Authorization Request Form (PA/RF), F-11018 (10/08).
  - ✓ Prior Authorization Amendment Request, F-11042 (10/08).
  - ✓ Prior Authorization/Psychotherapy Attachment (PA/PSYA), F-11031 (10/08).
  - ✓ Outpatient Mental Health Assessment and Treatment/Recovery Plan, F-11103 (10/08).
  - ✓ Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA), F-11033 (10/08).
  - ✓ Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA), F-11088 (10/08).

  Providers may also order copies from Provider Services.

The changes were made to do the following:

- Provide efficiencies for both providers and Provide efficiencies for both providers and ForwardHealth.
- Accommodate changes required for full National Provider Identifier implementation.
- Align with Health Insurance Portability and Accountability Act of 1996 (HIPAA) terminology.

A separate *Update* will give providers a calendar of additional important dates related to implementation including when to begin submitting the revised PA forms.

Information in this *Update* applies to providers who provide services for BadgerCare Plus and Wisconsin Medicaid members.

## Changes to Prior Authorization with the Implementation of ForwardHealth interChange

In October 2008, the Department of Health and Family Services (DHFS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS). ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization (PA) requests through the secure ForwardHealth Portal. Refer to the March 2008 *ForwardHealth Update* (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based

Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

With the implementation of the ForwardHealth interChange system, important changes will be made to PA forms and procedures that are detailed in this *Update*. These changes are not policy or coverage related (e.g., PA requirements, documentation requirements). The changes were made to:

- Provide efficiencies for both providers and ForwardHealth. Providers will be able to submit PA requests and receive decisions and requests for additional information via the ForwardHealth Portal.
- Accommodate changes required for full National Provider Identifier (NPI) implementation. Prior authorization forms were revised to include elements for providers to indicate NPI and taxonomy information.
- Align with Health Insurance Portability and Accountability Act of 1996 (HIPAA) terminology.

*Note:* Specific implementation dates will be published in a separate *Update*. Use of information presented in this *Update* prior to implementation may result in returned PA requests.

Information in this *Update* applies to providers who provide services for BadgerCare Plus and Wisconsin Medicaid members.

## Submitting Prior Authorization Requests

Using the ForwardHealth Portal, providers will be able to submit PA requests for *all* services requiring PA. In addition to the Portal, providers may submit PA requests via any of the following:

- Fax at (608) 221-8616.
- Mail to the following address:

  ForwardHealth
  Prior Authorization
  Ste 88
  6406 Bridge Rd
  Madison WI 53784-0088

Watch for future publications for information on submitting PA requests via the Portal.

## Prior Authorization Numbers

The PA number will no longer be pre-printed on the Prior Authorization Request Form (PA/RF), F-11018 (10/08). As a result, providers will be able to download and print the form from the Portal and no longer have to order pre-printed forms from ForwardHealth. Upon receipt of the form, ForwardHealth will assign a PA number to each PA request.

The PA number will consist of 10 digits, containing valuable information about the PA (e.g., the date the PA request was received by ForwardHealth, the medium used to submit the PA request). Refer to Attachment 1 of this *Update* for information about interpreting PA numbers.

## Revisions to the Prior Authorization Request Form and Instructions

The following revisions have been made to the PA/RF:

- The PA number is eliminated from the form.
- The paper PA/RF is a one-part form (no longer a two-part, carbonless form) that can be downloaded and printed. The PA/RF is available in two formats on the Portal — Microsoft® Word and Portable Document Format (PDF).

- Checkboxes are added for HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP) (Element 1) to create efficiencies for providers who render services to members in Wisconsin Medicaid, BadgerCare Plus, and WCDP.
- The term "rendering provider" replaces "performing provider" to align with HIPAA terminology.
- Billing and rendering provider taxonomy code fields are added (Elements 5b and 17) to accommodate NPI implementation.
- In the billing provider's name and address fields, providers are now required to include the ZIP+4 code (Element 4) to accommodate NPI implementation.

## Prior Authorization Attachments

With the implementation of ForwardHealth interChange, outpatient mental health services providers submitting a paper PA request will be required to use the revised Prior Authorization/Psychotherapy Attachment (PA/PSYA), F-11031 (10/08); Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA), F-11033 (10/08); and Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA), F-11088 (10/08). While the basic information requested on the form has not changed, the format of the form has changed to accommodate NPI information and to add a barcode. ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests. The Outpatient Mental Health Assessment and Treatment/Recovery Plan, F-11103 (10/08), must be included with outpatient psychotherapy requests.

Refer to the following attachments for copies of the PA attachments for providers to photocopy and their accompanying completion instructions:

- Attachments 9 and 10 — PA/PSYA.
- Attachments 11 and 12— Outpatient Mental Health Assessment and Treatment/Recovery Plan.
- Attachments 13 and 14 — PA/EA.
- Attachments 15 and 16 — PA/HBA.

## Obtaining Prior Authorization Request Forms and Attachments

The PA/RF, PA/PSYA, Outpatient Mental Health Assessment and Treatment/Recovery Plan, PA/EA, and PA/HBA are available in fillable PDF or fillable Microsoft® Word from the Forms page at *dhfs.wisconsin.gov/ForwardHealth/* prior to implementation and will be available from the Portal after implementation.

The fillable PDF is accessible using Adobe Reader® and may be completed electronically. To use the fillable PDF, click on the dash-outlined boxes and enter the information. Press the "Tab" key to move from one box to the next.

To request a paper copy of the PA/RF, PA/PSYA, Outpatient Mental Health Assessment and Treatment/Recovery Plan, PA/EA, and PA/HBA for photocopying, call Provider Services at (800) 947-9627. Questions about the forms may also be directed to Provider Services.

In addition, a copy of any PA form and/or attachment is available by writing to ForwardHealth. Include a return address, the name of the form, and the number of the form (if applicable) and mail the request to the following address:

ForwardHealth
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

## Prior Authorization Decisions

The PA review process continues to include both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

| Prior Authorization Status | Description |
|---|---|
| Approved | The PA request was approved as requested. |
| Approved with Modifications | The PA request was approved with modifications to what was requested. |
| Denied | The PA request was denied. |
| Returned — Provider Review | The PA request was returned to the provider for correction or for additional information. |
| Pending — Fiscal Agent Review | The PA request is being reviewed by the Fiscal Agent. |
| Pending — Dental Follow-up | The PA request is being reviewed by a Fiscal Agent dental specialist. |
| Pending — State Review | The PA request is being reviewed by the State. |
| Suspend — Provider Sending Information | The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper. |
| Inactive | The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing. |

## Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The new decision notice letter or returned provider review letter implemented with ForwardHealth interChange will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), not to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

### *Returned Provider Review Letter*

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth.

Providers can also correct PAs that have been placed in returned provider review status in the Portal.

The provider's paper documents submitted with the PA request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the PA request.

*Note:* When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

### *Thirty Days to Respond to the Returned Provider Review Letter*

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the Portal. If the provider's response is received within 30 calendar days, ForwardHealth will still consider the original receipt date on the PA request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This will result in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through the WiCall Automated Voice Response system. Watch for future publications for more information regarding checking PA status via WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

### *Listing Procedure Codes Approved as a Group on the Decision Notice Letter*

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

## New Amendment Process

Providers are required to use the Prior Authorization Amendment Request, F-11042 (10/08), to amend an approved or modified PA request. The Prior Authorization Amendment Request was revised to accommodate NPI information. Instructions for completion of the Prior Authorization Amendment Request are located in Attachment 7. Attachment 8 is a copy of the revised Prior Authorization Amendment Request for providers to photocopy.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted through the Portal as well as by mail or fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper forms.

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days

from the receipt of all the information necessary. If the provider submitted the amendment request via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), not to the address the provider wrote on the amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

### *Returned Amendment Provider Review Letter*

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA appears currently in the system and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days the amendment request status becomes inactive and the provider is required to submit a new amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

*Note:* When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

## Valid Diagnosis Codes Required

Effective with implementation, the PA/RF will be monitored for the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific, diagnosis codes may have up to five digits.

Prior authorization requests sent by mail or fax with an invalid diagnosis code will be returned to the provider. Providers using the Portal will receive a message that the diagnosis code is invalid and will be allowed to correct the code and submit the PA request.

## Information Regarding Managed Care

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health and Family Services (DHFS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHFS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *dhfs.wisconsin.gov/forwardhealth/*.

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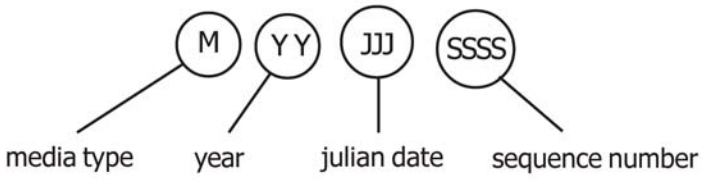
# ATTACHMENT 1
# Interpreting Prior Authorization Numbers

Each prior authorization (PA) request is assigned a unique PA number. This number identifies valuable information about the PA. The following diagram and table provide detailed information about interpreting the PA number.




| Type of Number and Description | Applicable Numbers and Description |
|---|---|
| Media — One digit indicates media type. | Digits are identified as follows:<br>1= paper; 2 = fax; 3 = Specialized Transmission Approval Technology-Prior Authorization (STAT-PA); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = National Council for Prescription Drug Programs (NCPDP) transaction |
| Year — Two digits indicate the year ForwardHealth received the PA request. | For example, the year 2008 would appear as 08. |
| Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request. | For example, February 3 would appear as 034. |
| Sequence number — Four digits indicate the sequence number. | The sequence number is used internally by ForwardHealth. |

# ATTACHMENT 2
# Prior Authorization Request Form (PA/RF) Completion Instructions for Outpatient Mental Health Services

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. The use of this form is mandatory to receive PA of certain procedures/services/items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with the Prior Authorization/Psychotherapy Attachment (PA/PSYA), F-11031; Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA), F-11033; or the Prior Authorization/Health and Behavior Attachment (PA/HBA), F-11088, by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I — PROVIDER INFORMATION**

**Element 1 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)**
Enter an "X" in the box next to HealthCheck "Other Services" if the services requested on the Prior Authorization Request Form (PA/RF), F-11018, are for HealthCheck "Other Services." Enter an "X" in the box next to Wisconsin Chronic Disease Program (WCDP) if the services requested on the PA/RF are for a WCDP member.

**Element 2 — Process Type**
Enter process type "126" for psychotherapy. The process type is a three-digit code used to identify a category of service requested.

**Element 3 — Telephone Number — Billing Provider**
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

**Element 4 — Name and Address — Billing Provider**
Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and the four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

**Element 5a — Billing Provider Number**
Enter the National Provider Identifier (NPI) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

**Element 5b — Billing Provider Taxonomy Code**
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of the billing provider in Element 5a.

**SECTION II — MEMBER INFORMATION**

**Element 6 — Member Identification Number**
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's Enrollment Verification System (EVS) to obtain the correct number.

**Element 7 — Date of Birth — Member**
Enter the member's date of birth in MM/DD/CCYY format.

**Element 8 — Address — Member**
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

**Element 9 — Name — Member**
Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

**Element 10 — Gender — Member**
Enter an "X" in the appropriate box to specify male or female.

**SECTION III — DIAGNOSIS / TREATMENT INFORMATION**

**Element 11 — Diagnosis — Primary Code and Description**
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested. A diagnosis code is not required on PA requests for psychiatric evaluation or diagnostic tests.

**Element 12 — Start Date — SOI (not required)**

**Element 13 — First Date of Treatment — SOI (not required)**

**Element 14 — Diagnosis — Secondary Code and Description**
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.
A diagnosis code is not required on PA requests for psychiatric evaluation or diagnostic tests.

**Element 15 — Requested PA Start Date**
Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested. If backdating is requested, include the clinical rationale for starting before PA was received. Backdating is not allowed on subsequent PA requests. The maximum backdating allowed is 10 working days from the date of receipt at Wisconsin Medicaid.

**Element 16 — Rendering Provider Number**
Enter the NPI of the provider who will be performing the service, *only* if the NPI is different from the NPI of the billing provider listed in Element 5a.

**Element 17 — Rendering Provider Taxonomy Code**
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider who will be performing the service, *only* if this code is different from the taxonomy code listed for the billing provider in Element 5b.

**Element 18 — Procedure Code**
Enter the appropriate *Current Procedural Terminology* (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code for each service/procedure/item requested.

**Element 19 — Modifiers**
Enter the modifier(s) corresponding to the service code listed if a modifier is required.

**Element 20 — POS**
Enter the appropriate place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed.

**Element 21 — Description of Service**
Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.

**Element 22 — QR**
Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed. Refer to Attachment 6 for rounding guidelines.

**Element 23 — Charge**
Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

*Note:* The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the Department of Health Services.

**Element 24 — Total Charges**
Enter the anticipated total charges for this request.

**Element 25 — Signature — Requesting Provider**
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

**Element 26 — Date Signed**
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

# ATTACHMENT 3
# Prior Authorization Request Form (PA/RF)
# (for photocopying)

(A copy of the "Prior Authorization Request Form [PA/RF]" is located on the following page.)

**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-11018 (10/08)

**STATE OF WISCONSIN**
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

# FORWARDHEALTH
# PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

## SECTION I — PROVIDER INFORMATION

| 1. Check only if applicable<br>❑ HealthCheck "Other Services"<br>❑ Wisconsin Chronic Disease Program (WCDP) | 2. Process Type | 3. Telephone Number — Billing Provider |
|---|---|---|
| 4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code) | | 5a. Billing Provider Number<br>5b. Billing Provider Taxonomy Code |

## SECTION II — MEMBER INFORMATION

| 6. Member Identification Number | 7. Date of Birth — Member | 8. Address — Member (Street, City, State, ZIP Code) |
|---|---|---|
| 9. Name — Member (Last, First, Middle Initial) | 10. Gender — Member<br>❑ Male ❑ Female | |

## SECTION III — DIAGNOSIS / TREATMENT INFORMATION

| 11. Diagnosis — Primary Code and Description | 12. Start Date — SOI | 13. First Date of Treatment — SOI |
|---|---|---|
| 14. Diagnosis — Secondary Code and Description | 15. Requested PA Start Date | |

| 16. Rendering Provider Number | 17. Rendering Provider Taxonomy Code | 18. Service Code | 19. Modifiers 1 | 2 | 3 | 4 | 20. POS | 21. Description of Service | 22. QR | 23. Charge |
|---|---|---|---|---|---|---|---|---|---|---|
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An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

| 24. Total Charges | |
|---|---|

| 25. **SIGNATURE** — Requesting Provider | 26. Date Signed |
|---|---|

DT-PA049-049

# ATTACHMENT 4
# Sample Prior Authorization Form (PA/RF) for Psychotherapy Services

(The sample "Prior Authorization Request Form [PA/RF]" for psychotherapy services is located on the following page.)

**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-11018 (10/08)

**STATE OF WISCONSIN**
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

## FORWARDHEALTH
# PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

### SECTION I — PROVIDER INFORMATION

| 1. Check only if applicable | 2. Process Type | 3. Telephone Number — Billing Provider |
|---|---|---|
| ❑ HealthCheck "Other Services"<br>❑ Wisconsin Chronic Disease Program (WCDP) | **126** | **(555) 555-5555** |

| 4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code) | 5a. Billing Provider Number | 5b. Billing Provider Taxonomy Code |
|---|---|---|
| **I.M. Billing Provider**<br>**609 Willow St**<br>**Anytown WI 55555-1234** | **0123456780** | **123456789X** |

### SECTION II — MEMBER INFORMATION

| 6. Member Identification Number | 7. Date of Birth — Member | 8. Address — Member (Street, City, State, ZIP Code) |
|---|---|---|
| **1234567890** | **MM/DD/CCYY** | **322 Ridge St**<br>**Anytown WI 55555** |

| 9. Name — Member (Last, First, Middle Initial) | 10. Gender — Member |
|---|---|
| **Member, Im A.** | ❑ Male ☒ Female |

### SECTION III — DIAGNOSIS / TREATMENT INFORMATION

| 11. Diagnosis — Primary Code and Description | 12. Start Date — SOI | 13. First Date of Treatment — SOI |
|---|---|---|
| **296.22 – Major depressive disorder, single episode, moderate** | | |

| 14. Diagnosis — Secondary Code and Description | 15. Requested PA Start Date |
|---|---|
| **314.00 – Attention-deficit disorder, predominantly inattentive type** | **MM/DD/CCYY** |

| 16. Rendering Provider Number | 17. Rendering Provider Taxonomy | 18. Service Code | 19. Modifiers 1 | 2 | 3 | 4 | 20. POS | 21. Description of Service | 22. QR | 23. Charge |
|---|---|---|---|---|---|---|---|---|---|---|
| **9876543210** | **012345678X** | **90806** | **HP** | | | | **11** | **Individual psychotherapy** | **6** | **XXX.XX** |
| **9876543210** | **012345678X** | **90847** | **HP** | | | | **11** | **Family psychotherapy** | **3** | **XXX.XX** |
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**Sample Prior Authorization Request Form [PA/RF] for Psychotherapy Services**

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

| 24. Total Charges | **XXX.XX** |
|---|---|

| 25. **SIGNATURE** — Requesting Provider | 26. Date Signed |
|---|---|
| *I.M. Provider* | **MM/DD/CCYY** |

# ATTACHMENT 5
# Sample Prior Authorization Form (PA/RF) for Evaluation Services

(The sample "Prior Authorization Request Form [PA/RF]" for evaluation services is located on the following page.)

**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-11018 (10/08)

**STATE OF WISCONSIN**
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

## FORWARDHEALTH
# PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

### SECTION I — PROVIDER INFORMATION

| 1. Check only if applicable | 2. Process Type | 3. Telephone Number — Billing Provider |
|---|---|---|
| ❑ HealthCheck "Other Services"<br>❑ Wisconsin Chronic Disease Program (WCDP) | **126** | **(555) 555-5555** |

| 4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code) | 5a. Billing Provider Number | 5b. Billing Provider Taxonomy Code |
|---|---|---|
| **I.M. Billing Provider**<br>**609 Willow St**<br>**Anytown WI 55555-1234** | **0123456780** | **123456789X** |

### SECTION II — MEMBER INFORMATION

| 6. Member Identification Number | 7. Date of Birth — Member | 8. Address — Member (Street, City, State, ZIP Code) |
|---|---|---|
| **1234567890** | **MM/DD/CCYY** | **322 Ridge St**<br>**Anytown WI 55555** |

| 9. Name — Member (Last, First, Middle Initial) | 10. Gender — Member |
|---|---|
| **Member, Im A.** | ❑ Male ☒ Female |

### SECTION III — DIAGNOSIS / TREATMENT INFORMATION

| 11. Diagnosis — Primary Code and Description | 12. Start Date — SOI | 13. First Date of Treatment — SOI |
|---|---|---|
| | | |

| 14. Diagnosis — Secondary Code and Description | 15. Requested PA Start Date |
|---|---|
| | **MM/DD/CCYY** |

| 16. Rendering Provider Number | 17. Rendering Provider Taxonomy | 18. Service Code | 19. Modifiers 1 | 2 | 3 | 4 | 20. POS | 21. Description of Service | 22. QR | 23. Charge |
|---|---|---|---|---|---|---|---|---|---|---|
| **9876543210** | **012345678X** | **90801** | **HP** | | | | **11** | **Psych Diag. Interview Examination** | **2** | **XXX.XX** |
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**Sample Prior Authorization Request Form [PA/RF] for Evaluation Services**

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

| 24. Total Charges | **XXX.XX** |
|---|---|

| 25. **SIGNATURE** — Requesting Provider | 26. Date Signed |
|---|---|
| *I.M. Provider* | **MM/DD/CCYY** |

# ATTACHMENT 6
# Rounding Guidelines for Outpatient Mental Health Services

The following table illustrates the rules of rounding and gives the appropriate billing unit for all services *except* pharmacologic management and electroconvulsive therapy.

Providers should use these rounding guidelines only when 1.0 unit of service is equal to one hour. Providers should follow the time specified in the procedure code description for all other codes.

| Outpatient Mental Health Services | |
|---|---|
| **Time (Minutes)** | **Unit(s) Billed** |
| 1-6 | .1 |
| 7-12 | .2 |
| 13-18 | .3 |
| 19-24 | .4 |
| 25-30 | .5 |
| 31-36 | .6 |
| 37-42 | .7 |
| 43-48 | .8 |
| 49-54 | .9 |
| 55-60 | 1.0 |

The following table illustrates the rules of rounding and gives the appropriate billing unit for pharmacologic management. Providers should use these rounding guidelines only when 1.0 unit of service is equal to 15 minutes. Providers should follow the time specified in the procedure code description for all other codes.

| Pharmacologic Management Rounding Guidelines | |
|---|---|
| **Time (Minutes)** | **Unit(s) Billed** |
| 1-3 | .2 |
| 4-6 | .4 |
| 7-9 | .6 |
| 10-12 | .8 |
| 13-15 | 1.0 |
| 16-18 | 1.2 |
| 19-21 | 1.4 |
| 22-24 | 1.6 |
| 25-27 | 1.8 |
| 28-30 | 2.0 |

Electroconvulsive therapy reimbursement is made on a daily basis; therefore, there are no rounding guidelines for this service.

# ATTACHMENT 7
# Prior Authorization Amendment Request Completion Instructions

(A copy of the "Prior Authorization Amendment Request Completion Instructions" is located on the following pages.)

(This page was intentionally left blank.)

# FORWARDHEALTH
# PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers are required to use the Prior Authorization Amendment Request, F-11042, to request an amendment to a PA. The use of this form is mandatory when requesting an amendment to a PA. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization Amendment Request to the PA Decision Notice of the PA to be amended along with physician's orders, if applicable, (within 90 days of the dated signature) and send it to ForwardHealth. Providers may submit the Prior Authorization Amendment Request to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

## SECTION I — MEMBER INFORMATION

**Element 1 — Original PA Number**
Enter the unique PA number from the original PA to be amended.

**Element 2 — Process Type**
Enter the process type as indicated on the PA to be amended.

**Element 3 — Member Identification Number**
Enter the member ID as indicated on the PA to be amended.

**Element 4 — Name — Member**
Enter the name of the member as indicated on the PA to be amended.

## SECTION II — PROVIDER INFORMATION

**Element 5 — Billing Provider Number**
Enter the billing provider number as indicated on the PA to be amended.

**Element 6 — Name — Billing Provider**
Enter the name of the billing provider as indicated on the PA to be amended.

## SECTION III — AMENDMENT INFORMATION

**Element 7 — Address — Billing Provider**
Enter the address of the billing provider (include street, city, state, and ZIP+4 code) as indicated on the PA to be amended.

**Element 8 — Requested Start Date**
Enter the requested start date for the amendment in MM/DD/CCYY format if a specific start date is required.

**Element 9 — Requested End Date (If Different from Expiration Date of Current PA)**
Enter the requested end date for the amendment in MM/DD/CCYY format if the end date is different that the current expiration date.

**Element 10 — Reasons for Amendment Request**
Enter an "X" in the box next to each reason for the amendment request. Check all that apply.

**Element 11 — Description and Justification for Requested Change**
Enter the specifics and supporting rationale of the amendment request related to each reason indicated in Element 10.

**Element 12 — Are Attachments Included?**
Enter an "X" in the appropriate box to indicate if attachments are or are not included with the amendment request. If Yes, specify all attachments that are included.

**Element 13 — Signature — Requesting Provider**
Enter the signature of the provider that requested the original PA.

**Element 14 — Date Signed — Requesting Provider**
Enter the date the amendment request was signed by the requesting provider in MM/DD/CCYY format.

# ATTACHMENT 8
# Prior Authorization Amendment Request (for photocopying)

(A copy of the "Prior Authorization Amendment Request" is located on the following page.)

**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-11042 (10/08)

**STATE OF WISCONSIN**
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

# FORWARDHEALTH
# PRIOR AUTHORIZATION AMENDMENT REQUEST

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Refer to the Prior Authorization Amendment Request Completion Instructions, F-11042A, for detailed information on completing this form.

## SECTION I — MEMBER INFORMATION

| 1. Original PA Number | 2. Process Type | 3. Member Identification Number |
|---|---|---|
| | | |

4. Name — Member (Last, First, Middle Initial)

## SECTION II — PROVIDER INFORMATION

| 5. Billing Provider Number | 7. Address — Billing Provider (Street, City, State, ZIP+4 Code) |
|---|---|
| 6. Name — Billing Provider | |

## SECTION III — AMENDMENT INFORMATION

| 8. Requested Start Date | 9. Requested End Date (If Different from Expiration Date of Current PA) |
|---|---|
| | |

10. Reasons for Amendment Request (Check All That Apply)

- ❑ Change Billing Provider Number
- ❑ Add Procedure Code / Modifier
- ❑ Change Procedure Code / Modifier
- ❑ Change Diagnosis Code
- ❑ Change Grant or Expiration Date
- ❑ Discontinue PA
- ❑ Change Quantity
- ❑ Other (Specify)_____

11. Description and Justification for Requested Change

12. Are Attachments Included? ❑ Yes ❑ No
If Yes, specify attachments below.

| 13. **SIGNATURE** — Requesting Provider | 14. Date Signed — Requesting Provider |
|---|---|
| | |

# ATTACHMENT 9
# Prior Authorization/Psychotherapy Attachment (PA/PSYA) Completion Instructions

(A copy of the "Prior Authorization/Psychotherapy Attachment [PA/PSYA] Completion Instructions" is located on the following pages.)

# FORWARDHEALTH
# PRIOR AUTHORIZATION / PSYCHOTHERAPY ATTACHMENT (PA/PSYA)
# COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of the ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The Prior Authorization/Psychotherapy Attachment (PA/PSYA), F-11031, must be submitted with the request for outpatient mental health services. Use of the accompanying Outpatient Mental Health Assessment and Treatment/Recovery Plan form, F-11103, is mandatory when requesting PA for certain services.

Attach the completed PA/PSYA, the Outpatient Mental Health Assessment and Treatment/Recovery Plan form, and physician prescription (if necessary) to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**GENERAL INSTRUCTIONS**
The information contained in the PA/PSYA is used to make a decision about the amount and type of psychotherapy that is approved for ForwardHealth reimbursement. Thoroughly complete each section and include information that supports the medical necessity of the services being requested. Where noted in these instructions, material from personal records may be substituted for the information requested on the form. *Indicate on the PA/PSYA the intended use of the attached materials.*

Prior authorization for psychotherapy is not granted when another provider already has an approved PA for psychotherapy services for the same member. In these cases, ForwardHealth recommend that the recipient request that previous providers notify ForwardHealth that they have discontinued treatment with this member. The member may also submit a signed statement of his or her desire to change providers and include the date of the change. The new provider's PA may not overlap with the previous provider's PA.

**SECTION I — MEMBER INFORMATION**

**Element 1 — Name — Member**
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**
Enter the date of birth of the member (in MM/DD/CCYY format).

**Element 3 — Member Identification Number**
Enter the Member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

## SECTION II — PROVIDER INFORMATION

**Element 4 — Name and Address — Rendering Provider**
Enter the name and address (street, city, state, ZIP+4 code) of the therapist who will be providing treatment.

**Element 5 — Rendering Provider National Provider Identifier**
Enter the National Provider Identifier of the rendering provider.

**Element 6 — Telephone Number — Rendering Provider**
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the rendering provider.

**Element 7 — Discipline — Rendering Provider**
Enter the discipline (credentials) of the therapist who will be providing treatment. The discipline should correspond with the name listed in Element 4.

## SECTION III — SERVICE REQUEST

Based on the information recorded on the Outpatient Mental Health Assessment and Treatment/Recovery Plan, the following services are requested.

**Element 8 — Number of Minutes Per Session**
Indicate the length of session for each format listed.

**Element 9 — Frequency of Requested Sessions**
Enter the anticipated frequency of requested sessions. If requesting sessions more frequently than once per week, describe why they are needed. If a series of treatments that are not regular is anticipated (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment requested, the time period over which the treatment is requested, and the expected pattern of treatment.

**Element 10 — Total Number of Sessions / Hours Requested for This PA Period**
Indicate the total hours of treatment requested for this PA period, based on the information entered in Elements 21 and 22 of the PA/RF, and the duration of this request. (Services at intensities lower than an average of one hour weekly may be approved for up to six months' duration.) *This quantity should match the quantity(ies) in Element 22 of the PA/RF.*

**Element 11 — Treatment Approach**
Indicate the type of treatment utilized. The treatment approach utilized must be consistent with the diagnosis and symptoms, and its effectiveness must be supported by clinical research.

**Element 12 — Estimated Termination Date**
Indicate the estimated date for meeting long-term treatment goals.

**Element 13 — Signature — Rendering Provider**
Enter the signature of the rendering provider.

**Element 14 — Date Signed**
Enter the date the rendering provider signed the PA/PSYA (in MM/DD/CCYY format).

# ATTACHMENT 10
# Prior Authorization/Psychotherapy Attachment (PA/PSYA) (for photocopying)

(A copy of the "Prior Authorization/Psychotherapy Attachment [PA/PSYA]" is located on the following page.)

## FORWARDHEALTH
# PRIOR AUTHORIZATION / PSYCHOTHERAPY ATTACHMENT (PA / PSYA)

Providers may submit prior authorization (PA) requests to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Psychotherapy Attachment (PA/PSYA) Completion Instructions, F-11031A. Failure to complete all elements could result in return or denial of PA request. Attach a copy of the member's assessment and treatment/recovery plan. Providers may submit this information on a new optional form, the Outpatient Mental Health Assessment and Treatment/Recovery Plan, F-11103.

**SECTION I — MEMBER INFORMATION**

| 1. Name — Member (Last, First, Middle Initial) | 2. Date of Birth — Member | 3. Member Identification Number |
|---|---|---|
| | | |

**SECTION II — PROVIDER INFORMATION**

| 4. Name and Address — Rendering Provider | 5. Rendering Provider's National Provider Identifier |
|---|---|
| | |
| 6. Telephone Number — Rendering Provider | 7. Discipline — Rendering Provider |
| | |

**SECTION III — SERVICE REQUEST**

Based on the information in the member's assessment and treatment/recovery plan or recorded on the optional Department of Health Services Outpatient Mental Health Assessment and Treatment/Recovery Plan, the following services are requested.

8. Number of Minutes Per Session

   Individual _____ Group _____ Family _____ Other _____

9. Frequency of Requested Sessions (Services in excess of once weekly require specific justification.)

   Monthly _____ Twice / month _____ Once / week _____ Other _____

10. Total Number of Sessions / Hours Requested for This PA Period

11. Treatment Approach

12. Estimated Termination Date

| 13. **SIGNATURE** — Rendering Provider | 14. Date Signed |
|---|---|
| | |

# ATTACHMENT 11
# Outpatient Mental Health Assessment and Treatment/Recovery Plan Completion Instructions

(A copy of the "Outpatient Mental Health Assessment and Treatment/Recovery Plan Completion Instructions" is located on the following pages.)

**FORWARDHEALTH**

# OUTPATIENT MENTAL HEALTH ASSESSMENT AND TREATMENT / RECOVERY PLAN COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The Outpatient Mental Health Assessment and Treatment/Recovery Plan, F-11103, may be used by providers of mental health outpatient services to document their assessment of a member's clinical condition and treatment/recovery plan. This information provides the clinical information required to request prior authorization (PA) for services covered by ForwardHealth.

The use of this form is mandatory when requesting PA for certain services. Attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Attach the completed Prior Authorization/Psychotherapy Attachment (PA/PSYA), F-11031, the member's assessment and treatment/recovery plan, and the physician prescription (if necessary) to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

## GENERAL INSTRUCTIONS

Complete Elements 1-7 when submitting the initial PA request and at least once every three years when the performing provider remains unchanged. For continuing PA on the same individual, it is not necessary to rewrite Elements 1-7; corrections/updates on information in Elements 1-7 should be made in Elements 8 through 10. When Elements 1-7 are not rewritten, submit a copy of what had previously been written, along with updated information in the remaining elements of the Outpatient Mental Health Assessment and Treatment/Recovery Plan. Medical consultants reviewing the PA requests have a file containing the previous requests, but they base their decisions on the clinical information submitted, so it is important to present all current, relevant clinical information.

## SECTION I — INITIAL ASSESSMENT / REASSESSMENT

Include the date of the initial assessment/reassessment (in MM/DD/CCYY format). Complete this section at least every three years.

### Element 1 — Presenting Problem

Enter the consumer's presenting problem.

### Element 2 — Diagnosis

Enter the date of the five-axis *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-3) diagnosis.

**Element 3 — Symptoms**
Enter the symptoms presented by the consumer that were used to formulate the diagnoses given in Element 1. Assess the severity of the symptoms and indicate them as mild, moderate, or severe.

**Element 4 — Strength-Based Assessment**
Document the assessment of the consumer, basing it on the consumer's strengths. Include current as well as historical biopsychosocial data. Include mental status, developmental, school/vocational, cultural, social, spiritual, medical, past and current traumas, substance use/dependence and outcome of treatment, and past mental health treatments and outcomes. Include the consumer's view of the issues. For a child, give the parent/primary caregiver's view of the issues. The provider may attach an assessment dated within three months of the request.

**Element 5**
Indicate the family/community support for this consumer. Indicate other services the consumer is receiving or to which he or she has been referred.

**Element 6**
Present the strengths that could impact the consumer's progress on goals; address any barriers to the progress.

**Element 7**
Indicate whether or not there has been a consultation to clarify the diagnosis and/or treatment and, if so, the credentials of the consultant. Indicate the date of the most recent consultation (in MM/DD/CCYY format). Briefly describe the results of the consultation or attach a copy of the report, if available.

**SECTION II — SUBSEQUENT ASSESSMENTS**
Not required when Initial Assessment section is completed. This section must be completed for subsequent reviews.

**Element 8**
Indicate any changes in Elements 1-7, including the current Global Assessment of Functioning, change in diagnoses (five axes), and supporting symptoms.

**Element 9**
Indicate the symptoms currently being exhibited by the consumer.

**SECTION III — TREATMENT / RECOVERY PLAN**

**Element 10**
Goals are general and answer the question, "What do the consumer and yourself, as therapist, want to accomplish in treatment?" Objectives are specific and answer the question, "What steps will the consumer and yourself, as therapist, be taking in therapy to help meet the stated goals?"

Indicate the goals of the consumer's treatment (short term for this PA period and long term for the next year).

For each objective, indicate the treatment modality (individual [I]; group [G]; family [F]; other [O] — specify) being implemented during this PA period. In the first column, indicate the behaviors you and the consumer have agreed upon as signs of improved functioning. In the second column, describe the progress, or lack thereof, in the behaviors identified in the first column since the last review. *Member report alone is not an observable sign*. In the third column, indicate changes in goals/objectives in the treatment/recovery plan.

**Element 11**
Indicate how the consumer's strengths are being utilized in meeting the goals of the treatment/recovery plan. If little or no progress is reported, discuss why you believe further treatment is needed for this consumer and how you plan to address the need for continued treatment. Discuss your plans for assisting the consumer in meeting his or her goals. If progress is reported, give rationale for continued services.

**Element 12**
Indicate whether the consumer is on any psychoactive medication and the date of the most recent medication check (in MM/DD/CCYY format). List psychoactive medications and target symptoms for each medication.

**SECTION IV — SIGNATURES**

**Element 13 — Signature — Rendering Provider**

**Element 14 — Date Signed**

**Element 15 — Signature — Consumer / Legal Guardian***

### Element 16 — Date Signed

* The outpatient psychotherapy clinic certification standards requiring the consumer to approve and sign the treatment plan and agree with the clinician on a course of treatment (HFS 36.16[3], Wis. Admin. Code) will be met if this form is signed by the consumer or a legal guardian for children.

# ATTACHMENT 12
# Outpatient Mental Health Assessment and Treatment/Recovery Plan (for photocopying)

(A copy of the "Outpatient Mental Health Assessment and Treatment/Recovery Plan" is located on the following pages.)

**FORWARDHEALTH**

# OUTPATIENT MENTAL HEALTH ASSESSMENT AND TREATMENT / RECOVERY PLAN

The use of this form is voluntary and optional and may be used in place of the consumer's assessment and treatment/recovery plan.

**SECTION I — INITIAL ASSESSMENT / REASSESSMENT**
Date of initial assessment / reassessment (MM/DD/CCYY) _____

1. Presenting Problem

2. Diagnosis (Use current *Diagnostic and Statistical Manual of Mental Disorders* [DSM] / *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* [DC: 0-3] code and description.)
   Axis I

   Axis II

   Axis III

   Axis IV (List psychosocial / environment problems.)

   Axis V (Current Global Assessment of Functioning [GAF].)

3. Symptoms (List consumer's symptoms in support of given DSM / DC:0-3 diagnoses.)

   Severity of Symptoms ❑ Mild ❑ Moderate ❑ Severe

4. Strength-Based Assessment (Include current and historical biopsychosocial data and how these factors will affect treatment. Also include mental status, developmental and intellectual functioning, school / vocational, cultural, social, spiritual, medical, past and current traumas, substance use / dependence and outcome of treatment, and past mental health treatments and outcomes.)

5. Describe the consumer's unique perspective and own words about how he or she views his or her recovery, experience, challenges, strengths, needs, recovery goals, priorities, preferences, values, and lifestyle of the consumer, areas of functional impairment, family and community support, and needs.

6. What do you anticipate as barriers / strengths toward progress and independent functioning?

*Continued*

## SECTION I — INITIAL ASSESSMENT / REASSESSMENT (Continued)

7. Has there been a consultation to clarify diagnosis / treatment? ❑ Yes ❑ No
   If so, by whom?
   ❑ Psychiatrist ❑ Ph.D. Psychologist ❑ Master's-Level Psychotherapist ❑ Other (Specify) _____
   ❑ Advanced Practice Nurse Prescriber-Psych / Mental Health Specialty
   ❑ Substance Abuse Counselor
   Date of latest consultation (MM/DD/CCYY)_____
   Provide results of consultation or attach report, if available.

## SECTION II — SUBSEQUENT ASSESSMENTS

Not required when Initial Assessment section is completed. This section must be completed for subsequent reviews.

8. Indicate any changes in Elements 1-7, including the current GAF, change in diagnoses (five axes), and symptoms in support of new diagnosis, including mental status.

9. Describe current symptoms / problems.

| | | | |
|---|---|---|---|
| ❑ Anxiousness | ❑ Homicidal | ❑ Oppositional | ❑ Somatic Complaints |
| ❑ Appetite Disruption | ❑ Hopelessness | ❑ Panic Attacks | ❑ Substance Use |
| ❑ Decreased Energy | ❑ Hyperactivity | ❑ Paranoia | ❑ Suicidal |
| ❑ Delusions | ❑ Impaired Concentration | ❑ Phobias | ❑ Tangential |
| ❑ Depressed Mood | ❑ Impaired Memory | ❑ Police Contact | ❑ Tearful |
| ❑ Disruption of Thoughts | ❑ Impulsiveness | ❑ Poor Judgment | ❑ Violence |
| ❑ Dissociation | ❑ Irritability | ❑ School / Home / Community Issues | ❑ Worthlessness |
| ❑ Elevated Mood | ❑ Manic | ❑ Self-Injury | |
| ❑ Guilt | ❑ Obsessions / Compulsions | ❑ Sexual Issues | |
| ❑ Hallucinations | ❑ Occupational Problems | ❑ Sleeplessness | |

❑ Other _____

## SECTION III — TREATMENT / RECOVERY PLAN

**Based on strength-based assessments.**

10. Treatment plan, as agreed upon with consumer.
    Short term (Three months) _____
    Long term (Within the next year) _____
    Specify objectives utilized to meet the goals.
    Indicate modality (Individual [I], group [G], family [F], other [O]) after each objective.

| | What are the therapist / consumer agreed-upon signs of improved functioning? As reported by _____ | Describe progress since last review as agreed-upon with consumer, or lack thereof, on each goal. For children, provide caregiver's report. | Changes in Goals / Objectives |
|---|---|---|---|
| 1 | | | |

*Continued*

**SECTION III — TREATMENT / RECOVERY PLAN (Continued)**

| | What are the therapist / consumer agreed-upon signs of improved functioning? As reported by _____ | Describe progress since last review as agreed-upon with consumer, or lack thereof, on each goal. For children, provide caregiver's report. | Identify changes in goals / objectives. |
|---|---|---|---|
| 2 | | | |
| 3 | | | |

11. How are consumer's strengths being utilized?

If little or no progress is reported, discuss why you believe further treatment is needed and how you plan to address the need for continued treatment. What strategies will you, as the therapist, use to assist the consumer in meeting his / her goals? If progress is reported, give rationale for continued services.

12. Is consumer taking any psychoactive medication? ❑ Yes ❑ No
Date of last medication check (MM/DD/CCYY) _____

List psychoactive medications and dosages.

Medication and Dosages _____ Target Symptoms _____
Medication and Dosages _____ Target Symptoms _____
Medication and Dosages _____ Target Symptoms _____

Is informed consent current for all medications? ❑ Yes ❑ No

**SECTION IV — SIGNATURES**

| 13. **SIGNATURE** — Rendering Provider | 14. Date Signed |
|---|---|
| 15. **SIGNATURE** — Consumer / Legal Guardian* | 16. Date Signed |

*The outpatient psychotherapy clinic certification standards requiring the consumer to approve and sign the treatment plan and agree with the clinician on a course of treatment (HFS 36.16[3], Wis. Admin. Code) will be met if this form is signed by the consumer/legal guardian for children.

# ATTACHMENT 13
# Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA) Completion Instructions

(A copy of the "Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment [PA/EA] Completion Instructions" is located on the following pages.)

**FORWARDHEALTH**

# PRIOR AUTHORIZATION / MENTAL HEALTH AND / OR SUBSTANCE ABUSE EVALUATION ATTACHMENT (PA/EA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain services. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Attach the completed Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA), F-11033, to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

## GENERAL INSTRUCTIONS

The information contained in the PA/EA is used to make a decision about the amount and type of mental health and substance abuse evaluation that is approved for ForwardHealth reimbursement. Thoroughly complete each section and include any information that supports the medical necessity of the services being requested.

## GENERAL INFORMATION ABOUT MENTAL HEALTH AND SUBSTANCE ABUSE EVALUATIONS

A mental health and substance abuse evaluation is an examination of the medical, biopsychosocial, behavioral, developmental, and environmental aspects of the member's situation and an assessment of the member's immediate and long-range therapeutic needs, developmental priorities, personal strengths and liabilities, and potential resources of the member's family and supports. Typically, the provider documents the results by using either the multiaxial system or nonaxial format, as described in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) developed by the American Psychiatric Association or the current *Diagnosis Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: 0-3* (DC:0-3) for children up to age 4.

A mental health and substance abuse evaluation is performed to serve as a guide to optimal treatment and prediction of outcomes for the patient, including diagnosing a mental disorder. Formulating a diagnosis is only the first step in an evaluation. To develop an adequate treatment plan, the clinician invariably requires considerable additional information about the person being evaluated beyond that required to make a diagnosis. The scope, as well as the medical necessity, of the evaluation is based on the presenting problem/circumstance, including symptoms indicative of a disorder (as defined in the current DSM/DC:0-3) and may include one or more of the following common clinical activities:

- Diagnostic/assessment interviews with the member.
- Assessment interviews with the member's family and supports.
- Review of history and previous treatment.
- Psychological testing.
- Documenting the results.

## SECTION I — MEMBER INFORMATION

**Element 1 — Name — Member**
Enter the member's last name, followed by his or her first name and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**
Enter the date of birth of the member (in MM/DD/YY format).

**Element 3 — Member Identification Number**
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

## SECTION II — PROVIDER INFORMATION

**Element 4 — Name — Rendering Provider**
Enter the name of the therapist who will be performing the evaluation.

**Element 5 — Rendering Provider National Provider Identifier**
Enter the National Provider Identifier of the rendering provider.

**Element 6 — Telephone Number — Rendering Provider**
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the rendering provider.

**Element 7 — Discipline — Rendering Provider**
Enter the discipline (credentials) of the therapist who will be performing the evaluation. The discipline should correspond with the name listed in Element 4.

## SECTION III — DOCUMENTATION

**Element 8**
Document the type of evaluation being requested and why it is needed. For instance, the evaluation may be a competency examination or it may be necessitated by the need to confirm a diagnosis. If the member was referred for evaluation, indicate who made the referral and why. Indicate how the results of the evaluation or testing will be used. Indicate how the member will benefit (e.g., indicate if the evaluation might be used to place the member in a less restrictive setting or to obtain guardianship that would be in the member's best interest). Providers requesting retroactive authorization must document the emergency situation on the court order that justifies such a request and indicate the initial date of service.

Requests for authorization to perform Central Nervous Assessments (*Current Procedural Terminology* procedure codes 96101-96120) should not be included in these requests.

**Element 9**
Indicate other evaluations the provider is aware of that have been conducted on this member in the past two years. Indicate why the requested evaluation does not duplicate earlier evaluations.

*A physician's prescription is not required for these evaluation services.*

**Element 10 — Signature — Rendering Provider**
Enter the signature of the rendering provider.

**Element 11 — Date Signed**
Enter the month, day, and year the PA/EA was signed (in MM/DD/CCYY format).

# ATTACHMENT 14
# Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA) (for photocopying)

(A copy of the "Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment [PA/EA]" is located on the following page.)

**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-11033 (10/08)

**STATE OF WISCONSIN**
HFS 107.13, Wis. Admin. Code

**FORWARDHEALTH**

# PRIOR AUTHORIZATION / MENTAL HEALTH AND / OR SUBSTANCE ABUSE EVALUATION ATTACHMENT (PA/EA)

Providers may submit prior authorization (PA) requests to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA) Completion Instructions, F-11033A. Failure to complete all elements could result in return or denial of PA requests.

**SECTION I — MEMBER INFORMATION**

| 1. Name — Member (Last, First, Middle Initial) | 2. Date of Birth — Member | 3. Member Identification Number |
|---|---|---|
| | | |

**SECTION II — PROVIDER INFORMATION**

| 4. Name — Rendering Provider | 5. Rendering Provider National Provider Identifier |
|---|---|
| | |
| 6. Telephone Number — Rendering Provider | 7. Discipline — Rendering Provider |
| | |

**SECTION III — DOCUMENTATION**

8. Indicate the type of evaluation being requested and why this evaluation is needed. If this was a referral, indicate who made the referral. Be specific as to how the member will benefit from this evaluation. (Do not include Central Nervous Assessments [*Current Procedural Terminology* procedure codes 96101-96120] in this request.)

9. Indicate other evaluations the provider is aware of that have been conducted on this member in the past two years. Indicate why the requested evaluation does not duplicate earlier evaluations.

| **10. SIGNATURE** — Rendering Provider | 11. Date Signed |
|---|---|
| | |

# ATTACHMENT 15
# Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA) Completion Instructions

(A copy of the "Prior Authorization/Health and Behavior Intervention Attachment [PA/HBA] Completion Instructions" is located on the following pages.)

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**FORWARDHEALTH**

# PRIOR AUTHORIZATION / HEALTH AND BEHAVIOR INTERVENTION ATTACHMENT (PA/HBA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain services. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Attach the completed Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA), F-11088, to the Prior Authorization Request Form (PA/RF), F-11018, and physician prescription and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

## INSTRUCTIONS

The information contained in the PA/HBA is used to make a decision about the amount and type of intervention that is approved for ForwardHealth reimbursement. Thoroughly complete each section and include any material that would be helpful to support the medical necessity of the services being requested. When noted in these instructions, material from personal records may be substituted for the information requested on the form. When substituting material from personal records, indicate the purpose of the materials.

Prior authorization for health and behavior interventions is not granted when another provider already has an approved PA for health and behavior intervention services for the same member. In these cases, ForwardHealth recommends that the member request that the other provider notify ForwardHealth that they have discontinued treatment with this member. The member may also submit a signed statement of his or her desire to change providers and include the date of the change. The new provider's PA may not overlap with the previous provider's PA.

## SECTION I — MEMBER INFORMATION

**Element 1 — Name — Member**
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**
Enter the date of birth of the member (in MM/DD/CCYY format).

**Element 3 — Member Identification Number**
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

## SECTION II — PROVIDER INFORMATION

**Element 4 — Name — Rendering Provider**
Enter the name of the therapist who will be providing the treatment.

**Element 5 — Rendering Provider National Provider Identifier**
Enter the National Provider Identifier of the rendering provider.

**Element 6 — Telephone Number — Rendering Provider**
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the rendering provider.

**Element 7 — Credentials — Rendering Provider**
Enter the credentials of the therapist who will be providing treatment. The discipline should correspond with the name listed in Element 4.

## SECTION III — CLINICAL INFORMATION

**Element 8 — Physical Health Diagnosis Related to the Need for Health and Behavior Interventions**
Enter the physical health diagnosis related to the need for health and behavior intervention services. Indicate the date the diagnosis was given and by whom.

**Element 9 — Biopsychosocial Factors Related to the Member's Physical Health Status**
Enter a summary of the biopsychosocial factors resulting from the member's physical health diagnosis as discovered in the health and behavior assessment. Indicate the date of the health and behavior assessment.

**Element 10 — Treatment Modalities**
Indicate the treatment modalities being implemented.

**Element 11 — Treatment Schedule**
Enter the anticipated length of sessions, frequency of sessions, and duration of services requested on this PA. If requesting sessions more frequently than once per week, indicate why they are needed. If a series of treatments is anticipated (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment requested, the time period over which the treatment is requested, and the expected pattern of treatment. This quantity should match the quantity(ies) in Element 22 of the PA/RF. (Services at intensities lower than the average of one hour weekly may be approved for a duration of up to six months.)

**Element 12 — Member's Measurable Goals of Treatment Modalities**
Indicate the member's measurable goals of each treatment modality being requested.

**Element 13 — Anticipated Duration of Treatment**
Indicate the anticipated duration of treatment to address the issues related to the identified physical health diagnosis listed in Element 8.

**Element 14 — Signature — Rendering Provider**
Enter the signature of the rendering provider.

**Element 15 — Date Signed**
Enter the month, day, and year the PA/HBA was signed (in MM/DD/CCYY format).

# ATTACHMENT 16
# Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA) (for photocopying)

(A copy of the "Prior Authorization/Health and Behavior Intervention Attachment [PA/HBA]" is located on the following page.)

**FORWARDHEALTH**

# PRIOR AUTHORIZATION / HEALTH AND BEHAVIOR INTERVENTION ATTACHMENT (PA/HBA)

Providers may submit the completed prior authorization (PA) request by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA) Completion Instructions, F-11088A.

**SECTION I — MEMBER INFORMATION**

| 1. Name — Member (Last, First, Middle Initial) | 2. Date of Birth — Member | 3. Member Identification Number |
|---|---|---|
| | | |

**SECTION II — PROVIDER INFORMATION**

| 4. Name — Rendering Provider | 5. Rendering Provider National Provider Identifier |
|---|---|
| 6. Telephone Number — Rendering Provider | 7. Credentials — Rendering Provider |

**SECTION III — CLINICAL INFORMATION**

8. Physical Health Diagnosis Related to the Need for Health and Behavior Interventions

9. Biopsychosocial Factors Related to the Member's Physical Health Status

10. Treatment Modalities

11. Treatment Schedule

12. Member's Measurable Goals of Treatment Modalities

13. Anticipated Duration of Treatment

| 14. **SIGNATURE** — Rendering Provider | 15. Date Signed |
|---|---|
| | |