

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 <input type="checkbox"/> HealthCheck "Other Services" <input type="checkbox"/> Wisconsin Chronic Disease Program (WCDP)	2. Process Type <div style="text-align: center;">120</div>	3. Telephone Number — Billing Provider <div style="text-align: center;">(XXX) XXX-XXXX</div>
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code) I.M. NIP PDN PAL 609 Willow St Anytown WI 55555-1234		5a. Billing Provider Number <div style="text-align: center;">0222222220</div>
		5b. Billing Provider Taxonomy Code <div style="text-align: center;">123456789X</div>

SECTION II — MEMBER INFORMATION

6. Member Identification Number <div style="text-align: center;">1234567890</div>	7. Date of Birth — Member <div style="text-align: center;">MM/DD/CCYY</div>	8. Address — Member (Street, City, State, ZIP Code) 322 Ridge St Anytown WI 55555
9. Name — Member (Last, First, Middle Initial) Member, Im A.	10. Gender — Member <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description <div style="text-align: center;">V46.11 Dependence on respirator</div>					12. Start Date — SOI		13. First Date of Treatment — SOI			
14. Diagnosis — Secondary Code and Description <div style="text-align: center;">343.9 Infantile cerebral palsy</div>					15. Requested PA Start Date <div style="text-align: center;">MM/DD/CCYY</div>					
16. Rendering Provider Number	17. Rendering Provider Taxonomy Code	18. Service Code	19. Modifiers				20. POS	21. Description of Service	22. QR	23. Charge
		99504	TD				12	PDN for ventilator dependent member 16 hours per day, 7 days per week X 52 weeks	5824	XXX.XX

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.

25. SIGNATURE — Requesting Provider <div style="text-align: center;">I.M NIP PDN PAL</div>	24. Total Charges <div style="text-align: center;">XXX.XX</div>
26. Date Signed <div style="text-align: center;">MM/DD/CCYY</div>	