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
- ❑ HealthCheck "Other Services"
- ❑ Wisconsin Chronic Disease Program (WCDP)

2. Process Type
120

3. Telephone Number — Billing Provider
(XXX) XXX-XXXX

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)
I.M. Billing Provider
609 Willow St
Anytown WI 55555-1234

5a. Billing Provider Number
0222222220

5b. Billing Provider Taxonomy Code
123456789X

SECTION II — MEMBER INFORMATION

6. Member Identification Number
1234567890

7. Date of Birth — Member
MM/DD/CCYY

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
❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description
250.0 — Diabetes II

12. Start Date — SOI

13. First Date of Treatment — SOI

11. Diagnosis — Primary Code and Description
401.9 — Hypertension NOS

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
		99600					**12**	**HHH — initial visit, 1 visit/day x 3 days/wk x 26 weeks**	**12 visits**	**XXX.XX**
								3 PRN visits/month x 1 month		

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
I.M. Provider

26. Date Signed
MM/DD/CCYY