

**FORWARDHEALTH
 PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)**

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 Prior Authorization Dental Request Form (PA/DRF) Completion Instructions, F-11035A.

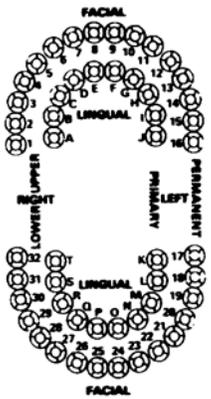
SECTION I — PROVIDER INFORMATION

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| 1. Check only if applicable <input type="checkbox"/> HealthCheck "Other Services" <input type="checkbox"/> Wisconsin Chronic Disease Program | 2. Process Type (Check one) <input checked="" type="checkbox"/> 124 (Dental) <input type="checkbox"/> 125 (Ortho) | 3. Telephone Number — Billing Provider (XXX) XXX-XXXX |
| 4. Name and Address — Billing Provider (Street, City, State, ZIP Code + 4) I.M. Provider 1 W. Williams St. Anytown, WI 55555-1234 | 5a. Billing Provider Number 011111110 | 5b. Billing Provider Taxonomy 123456789X |
| | 6a. Rendering Provider Number 022222220 | 6b. Rendering Provider Taxonomy 123456789X |

SECTION II — MEMBER INFORMATION

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|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| 7. Member Identification Number 1234567890 | 8. Date of Birth — Member MM/DD/CCYY | 9. Address — Member (Street, City, State, ZIP Code) 609 Willow St. Anytown, WI 55555 |
| 10. Name — Member (Last, First, Middle Initial) Member, Im A. | 11. Gender — Member <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female | |

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

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| 12. Place of Service <input checked="" type="checkbox"/> Dental Office (POS "11") <input type="checkbox"/> Outpatient Hospital (POS "22") <input type="checkbox"/> Ambulatory Surgical Center (POS "24") <input type="checkbox"/> Skilled Nursing Facility (POS "31") <input type="checkbox"/> Other (specify): | | | | | | | 13. Dental Diagram <ul style="list-style-type: none"> • Check periodontal case type if applicable. <input type="checkbox"/> I <input checked="" type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V • Cross out missing teeth. • Circle teeth to be extracted.  <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: auto;"> Staple X-Ray Envelope Here </div> | |
| 14. Area of Oral Cavity | 15. Tooth | 16. Procedure Code | 17. Modifier | 18. Description of Service | 19. Quantity Requested | 20. Charge | 21. Total Charges XXX.XX Number of X-rays 4 Type of X-rays 2 BW, 2 PA | |
| | | D5110 | | Complete denture - maxillary | 1 | XXX.XX | | |
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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, Medicaid reimbursement will be allowed only if the service is not covered by the Managed Care Program.

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| 22. SIGNATURE — Rendering Provider <i>I.M. Provider</i> | 23. Date Signed MM/DD/CCYY |
| 24. SIGNATURE — Member / Guardian (if applicable) | 25. Date Signed |