

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 135	3. Telephone Number — Billing Provider (555) 555-5555
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code) I.M. Billing Provider 609 Willow St. Anytown WI 55555-5555		5a. Billing Provider Number 0111111110 5b. Billing Provider Taxonomy Code 123456789X

SECTION II — MEMBER INFORMATION

6. Member Identification Number 1234567890	7. Date of Birth — Member MM/DD/YY	8. Address — Member (Street, City, State, ZIP+4 Code) 555 Willow Rd. Anytown WI 55555
9. Name — Member (Last, First, Middle Initial) Member, Im A.	10. Gender — Member <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description 518.83 — Chronic respiratory failure					12. Start Date — SOI		13. First Date of Treatment — SOI			
14. Diagnosis — Secondary Code and Description V46.1 — Dependence on respirator					15. Requested PA Start Date					
16. Rendering Provider Number	17. Rendering Provider Taxonomy Code	18. Procedure Code	19. Modifiers				20. POS	21. Description of Service	22. QR	23. Charge
		0946	1	2	3	4	31	Ventilator dependent, \$XXX.XX/day	31	X,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.

	24. Total Charges XX,XXX.XX
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25. SIGNATURE — Requesting Provider <i>I.M. Provider</i>	26. Date Signed MM/DD/CCYY
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