

**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 <p align="center">133</p>	3. Telephone Number — Billing Provider <p align="center">(XXX) XXX-XXXX</p>
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 <p align="center">022222220</p>
		5b. Billing Provider Taxonomy Code <p align="center">123456789X</p>

SECTION II — MEMBER INFORMATION

6. Member Identification Number <p align="center">1234567890</p>	7. Date of Birth — Member <p align="center">MM/DD/CCYY</p>	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 <p>203.0 Multiple myeloma</p>						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				20. POS	21. Description of Service	22. QR	23. Charge
		41.01	1	2	3	4	21	Bone marrow transplant	1	XXXX.XX
		0812					21	Cadaver donor		

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 I.M. Provider	24. Total Charges <p align="center">XXXX.XX</p>
26. Date Signed <p align="center">MM/DD/CCYY</p>	