

FORWARDHEALTH ATTESTATION TO ADMINISTER MAKENA INJECTIONS COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the services.

The use of this form is mandatory when requesting Attestation for Makena Injections. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Prescribers are required to complete and sign the Attestation to Administer Makena Injections, F-00508. Providers are required to attach the completed Attestation to Administer Makena Injections to a Prior Authorization Request Form (PA/RF), F-11018, and send the forms to ForwardHealth. Prescribers are required to retain a completed copy of the form.

Prescribing providers may submit the attestation request to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Prescribing providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Element 3 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

SECTION II — PRESCRIBER INFORMATION

Element 4 — Name — Prescriber

Enter the name of the prescriber.

Element 5 — National Provider Identifier (NPI) — Prescriber

Enter the 10-digit National Provider Identifier of the prescriber.

Element 6 — Address — Prescriber

Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 7 — Telephone Number — Prescriber

Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION

Element 8 — Diagnosis Code and Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description. The diagnosis code indicated must be an allowable diagnosis code.

Element 9

Indicate whether or not the member experienced difficulty with prior use of a 17P compound injection or whether or not there is a medical reason that prevents the use of a 17P compound injection. Explain in the space provided the difficulty with the prior use of a 17P compound injection or the medical reason that prevents the member from receiving treatment with a 17P compound injection.

SECTION IV — PRESCRIBER ATTESTATION DOCUMENTATION

Element 10 — Prescriber Attestation Documentation

The provider is required to read the attestation information of the form. By signing and dating Elements 11 and 12, the provider attests to the information in Element 10.

Element 11 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 12 — Date Signed

Enter the month, day, and year the form was signed in MM/DD/CCYY format.