

**FORWARDHEALTH  
PRIOR AUTHORIZATION / PHYSICIAN ATTACHMENT (PA/PA)**

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 (HFS 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, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when requesting PA for certain services or procedures. 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 case.

Attach the completed Prior Authorization/Physician Attachment (PA/PA), F-11016, to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

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

The provision of services which are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

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**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

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**SECTION II — PROVIDER INFORMATION**

4. Name — Rendering Provider	5. National Provider Identifier — Rendering Provider
6. Telephone Number — Rendering Provider	
7. Name — Ordering / Prescribing Physician	

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**SECTION III — SERVICE INFORMATION**

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A. Describe diagnosis and clinical condition pertinent to service or procedure requested.

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B. Describe medical history pertinent to service or procedure requested.

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C. Supply justification for service or procedure requested.

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D. **SIGNATURE** — Physician

Date Signed

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