

## FORWARDHEALTH PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1) 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 (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 to receive prior authorization (PA) of certain procedures/services/items. In addition to the Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1) form, F-11020, hearing instrument specialists and audiologists are required to include a completed Prior Authorization Request/Hearing Instrument and Audiological Services (PA/HIAS2) attachment, F-11021. Hearing instrument specialists are also required to include a completed Prior Authorization/Physician Otological Report (PA/POR), F-11019.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with all applicable service-specific attachments, 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 that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — PROVIDER INFORMATION

#### Element 1 — Process Type

Processing type "123" (hearing instruments) is preprinted in this element.

#### Element 2 — Telephone Number — Testing Center

Enter the telephone number, including the area code, of the testing center.

#### Element 3 — Name and Address — Testing Center

Enter the name and complete address (street, city, state, and ZIP+4 code) of the testing center. Providers are required to include both the ZIP+4 code for timely and accurate PA processing. The name listed in this element must correspond with the testing center's provider number listed in Element 4a.

#### Element 4a — Testing Center Provider Number

Enter the provider number of the testing center. The provider number in this element must correspond with the testing center name listed in Element 3.

#### Element 4b — Testing Center Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the testing center's provider number in Element 4a.

#### Element 5 — Name — Referring Physician

Enter the name of the referring physician.

#### Element 6a — Referring Physician Provider Number or License Number

Enter the provider number or license number of the referring physician.

#### Element 6b — Referring Physician Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the referring physician's provider number or license number in Element 6a.

## SECTION II — MEMBER INFORMATION

### Element 7 — Name and Address — Member

Enter the member's last name, followed by his or her 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. Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

### Element 8 — 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 identification number.

### Element 9 — Gender — Member

Enter an "X" in the appropriate box to specify male or female.

### Element 10 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format (e.g., September 8, 1966, would be 09/08/1966).

## SECTION III — DIAGNOSIS / TREATMENT INFORMATION

### Element 11 — Diagnosis — Code and Description

Enter an *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code and written description of the member's diagnosis.

### Element 12 — Rendering Provider Number

Enter the provider number of the provider who is requesting the service. Enter a number here only if this number is different from the testing center's provider number listed in Element 4a.

### Element 13 — Rendering Provider Taxonomy

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider who is requesting the service, *only* if this code is different from the taxonomy code listed for the testing center in Element 4b.

### Element 14 — Procedure Code

Enter the appropriate procedure code for each requested hearing instrument or related service.

### Element 15 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed if a modifier is required by BadgerCare Plus. Refer to service-specific publications for a list of allowable modifiers.

### Element 16 — POS

Enter the appropriate two-digit place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

### Element 17 — Description of Service

Enter the procedure code description of the requested hearing instrument or related service. If requesting a hearing aid, enter the manufacturer, model number and, if applicable, the size of the hearing aid (i.e., full shell, half shell, low profile).

### Element 18 — QR

Enter the appropriate quantity requested for each procedure code listed.

### Element 19 — Charge

When requesting a hearing aid model available through a volume purchase contract, enter the contracted purchase rate. When requesting a hearing aid style that is not available through a volume purchase contract, enter the actual or best estimate of the net cash outlay cost. When requesting a complex or high-tech hearing aid model, which is not available through a volume purchase contract, enter the actual or best estimate of the net cash outlay cost. When requesting a major repair for a contracted hearing aid model, enter the contracted repair rate. For all other services and hearing instruments, enter the usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

### Element 20 — Total Charges

Enter the anticipated total charge for this request.

**Element 21 — Signature — Requesting Provider**

The original signature of the requesting audiologist or hearing instrument specialist must appear in this element.

**Element 22 — Provider Type**

Check the appropriate box to indicate whether the requesting provider is an audiologist or a hearing instrument specialist.

**Element 23 — Date Signed**

Enter the month, day, and year the PA/HIAS1 was signed (in MM/DD/CCYY format).