

## FORWARDHEALTH PRIOR AUTHORIZATION REQUEST / HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2) 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. If necessary, attach additional pages if more space is needed. 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.

Providers are required to attach the completed Prior Authorization Request/Hearing Instrument and Audiological Services (PA/HIAS2) form, F-11021, and Prior Authorization Request/Physician Otological Report (PA/POR) form, F-11019, (if necessary) to the PA/HIAS1, F-11020, and physician prescription (if necessary) 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 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 — Name — Provider**

Enter the name of the requesting hearing instrument specialist or audiologist.

**Element 2 — National Provider Identifier**

Enter the National Provider Identifier of the requesting hearing instrument specialist or audiologist.

**Element 3 — Telephone Number — Provider**

Enter the telephone number, including area code, of the requesting hearing instrument specialist or audiologist.

**Element 4 — Address — Provider**

Enter the complete address of the requesting hearing instrument specialist or audiologist (including street, city, state, and ZIP+4 code).

### SECTION II — MEMBER INFORMATION

**Element 5 — Name — 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.

**Element 6 — Date of Birth — Member**

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

**Element 7 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters.

**Element 8 — Gender — Member**

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

**Element 9 — Has the Member Ever Used a Hearing Instrument?**

Enter an "X" in the appropriate box.

**Element 10 — Describe Prior Hearing Instrument Use**

Describe the member's prior hearing instrument use.

**Element 11 — Testing Date**

Enter the date, in MM/DD/CCYY format, of the audiological testing/evaluation.

**Element 12 — Test Reliability**

Enter an "X" in the appropriate box.

**SECTION III — DOCUMENTATION**

**Elements 13-15**

Document all audiological testing and results.

**Element 16 — Recommendations for a Hearing Instrument**

Describe recommendations for a hearing instrument.

**Element 17 — Signature — Requesting Provider**

Enter the signature of the requesting provider.

**Element 18 — Name — Requesting Provider**

Enter the requesting hearing instrument specialist or audiologist's name.

**Element 19 — Provider Type**

Enter an "X" in the appropriate box.

**Element 20 — Date Signed**

Enter the date the provider signed the request.