

**FORWARDHEALTH  
PRIOR AUTHORIZATION / DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA)**

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax 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 Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA) Completion Instructions, F-11030A.

**SECTION I — MEMBER INFORMATION**

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

**SECTION II — PROVIDER INFORMATION**

4. Name — Prescribing Physician	5. Prescribing Physician's National Provider Identifier
6. Telephone Number — Prescribing Physician	7. Telephone Number — Dispensing Provider

**SECTION III — SERVICE INFORMATION**

8. Describe the overall physical status of the member (mobility, self-care, strength, coordination).

9. Describe the medical condition of the member as it relates to the equipment / item requested (e.g., describe why the member needs this equipment).

*Continued*



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**SECTION III — SERVICE INFORMATION (continued)**

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10. Is the member able to operate the equipment / item requested?

- Yes             No — If not, who will do this?

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11. Is training provided or required?

- Yes             No — If not, who will do this?

Explain.

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12. State where equipment / item will be used.

- Home             Office  
 Nursing Home    Job  
 School

Describe type of dwelling and accessibility.

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13. State estimated duration of need.

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14. If renewal or continuation of DME authorization is requested, describe the following about the member, including current clinical condition, progress (improvement, no change, etc.), results, and the member's use of equipment / item prescribed.

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15. Indicate amount of oxygen to be administered.

\_\_\_\_ Liters per minute            \_\_\_\_ Continuous  
\_\_\_\_ Hours per day                \_\_\_\_ PRN  
\_\_\_\_ Days per week                \_\_\_\_ PaO<sub>2</sub>

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Attach a photocopy of the physician's prescription to this attachment. The prescription must be signed and dated within six months of receipt by ForwardHealth.

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16. **SIGNATURE** — Requesting Provider

17. Date Signed

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