

## FORWARDHEALTH PRIOR AUTHORIZATION / DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA) 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 when requesting PA for durable medical equipment (DME).

**Instructions:** Under HFS 106.02(9)(e), Wis. Admin. Code, the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests. The provider is responsible for submitting sufficient information to support the medical necessity of the requested equipment or supplies. If the space provided is not sufficient, attach additional pages for the provider's responses and/or an occupational or physical therapy report if available. All DME, including repairs, must be prescribed by a physician. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements.

Attach a photocopy of the physician's prescription to the completed Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA), F-11030. The prescription must be signed and dated within six months of receipt by ForwardHealth. Attach the PA/DMEA 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).

### SECTION I — MEMBER INFORMATION

#### Element 1 — 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 the spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Age — Member

Enter the age of the member in numerical form (e.g., 16, 21, 60).

#### Element 3 — Member Identification Number

Enter the memberID. Do not enter any other numbers or letters.

### SECTION II — PROVIDER INFORMATION

#### Element 4 — Name — Prescribing Physician

Enter the name of the prescribing physician.

#### Element 5 — Prescribing Physician's National Provider Identifier

Enter the National Provider Identifier (NPI) of the prescribing physician. The NPI in this element must correspond with the provider name listed in Element 4.

#### Element 6 — Telephone Number — Prescribing Physician

Enter the prescribing physician's telephone number, including area code.

**Element 7 — Telephone Number — Dispensing Provider**

Enter the dispensing provider's telephone number, including area code.

**SECTION III — SERVICE INFORMATION**

**Element 8**

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

**Element 9**

Describe the medical condition of the member as it relates to the equipment/item requested. Indicate why the member needs this equipment.

**Element 10**

Indicate if the member is able to operate the equipment/item requested.

**Element 11**

Indicate if training is provided or required.

**Element 12**

State where equipment/item will be used. Describe type of dwelling and accessibility.

**Element 13**

State estimated duration of need.

**Element 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.

**Element 15**

Indicate amount of oxygen to be administered.

**Element 16 — Signature — Requesting Provider**

Enter the signature of the requesting provider.

**Element 17 — Date Signed**

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

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.