

**FORWARDHEALTH  
PRIOR AUTHORIZATION / PSYCHOTHERAPY ATTACHMENT (PA / PSYA)**

Providers may submit prior authorization (PA) requests 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/Psychotherapy Attachment (PA/PSYA) Completion Instructions, F-11031A. Failure to complete all elements could result in return or denial of PA request. Attach a copy of the member's assessment and treatment/recovery plan. Providers may submit this information on a new optional form, the Outpatient Mental Health Assessment and Treatment/Recovery Plan, F-11103.

**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 and Address — Rendering Provider	5. Rendering Provider's National Provider Identifier
6. Telephone Number — Rendering Provider	7. Discipline — Rendering Provider

**SECTION III — SERVICE REQUEST**

Based on the information in the member's assessment and treatment/recovery plan or recorded on the optional Department of Health Services Outpatient Mental Health Assessment and Treatment/Recovery Plan, the following services are requested.

8. Number of Minutes Per Session

Individual \_\_\_\_\_ Group \_\_\_\_\_ Family \_\_\_\_\_ Other \_\_\_\_\_

9. Frequency of Requested Sessions (Services in excess of once weekly require specific justification.)

Monthly \_\_\_\_\_ Twice / month \_\_\_\_\_ Once / week \_\_\_\_\_ Other \_\_\_\_\_

10. Total Number of Sessions / Hours Requested for This PA Period

11. Treatment Approach

12. Estimated Termination Date

13. <b>SIGNATURE</b> — Rendering Provider	14. Date Signed
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