DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11035 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth 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 Dental Request Form (PA/DRF) Completion Instructions, F-11035A.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type (Check one)	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program	❑ 124 (Dental) ❑ 125 (Ortho)	

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number
	5b. Billing Provider Taxonomy Code
	6a. Rendering Provider Number
	6b. Rendering Provider Taxonomy Code

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP+4 Code)
10. Name — Member (Last, First, Middle Initial)	11. Gender — Member ❑ Male ❑ Female	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Place of Service
❑ Dental Office (POS "11") ❑ Outpatient Hospital (POS "22") ❑ Ambulatory Surgical Center (POS "24")
❑ Skilled Nursing Facility (POS "31") ❑ Other (specify): _____

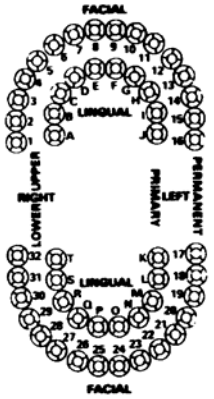
14. Area of Oral Cavity	15. Tooth	16. Procedure Code	17. Modifier	18. Description of Service	19. Quantity Requested	20. Charge

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the Managed Care Program.

21. Total Charges	$0.00

13. Dental Diagram

- Check periodontal case type if applicable.
  - ❑ I
  - ❑ II
  - ❑ III
  - ❑ IV
  - ❑ V
- Cross out missing teeth.
- Circle teeth to be extracted.



Staple X-Ray Envelope Here

Number of X-rays _____
Type of X-rays _____

22. **SIGNATURE** — Rendering Provider	23. Date Signed
24. **SIGNATURE** — Member / Guardian (if applicable)	25. Date Signed

Reset Form

DT-PA016-016