

**FORWARDHEALTH  
PRIOR AUTHORIZATION / ADULT MENTAL HEALTH DAY TREATMENT ATTACHMENT  
(PA/AMHDTA)**

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/Adult Mental Health Day Treatment Attachment (PA/AMHDTA) Completion Instructions, F-11038A.

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**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)

2. Age — Member

3. Member Identification Number

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**SECTION II — PROVIDER INFORMATION**

4. Name and Credentials — Requesting / Rendering Provider

5. Requesting / Rendering Provider's National Provider Identifier (NPI)

6. Telephone Number — Requesting / Rendering Provider

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**SECTION III — DOCUMENTATION**

7. Number of Hours per Week Requested

8. Estimated Final Treatment Date

9. Has the member had previous adult mental health day treatment at the provider's facility or elsewhere?

Yes       No       Unknown

If "yes," list dates and locations.

10. Evaluation(s) (Include date[s], tests used, and results.)

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*Continued*



DT-PA005-005

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**SECTION III — DOCUMENTATION (Continued)**

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11. Attach Section I of the member's most recent Functional Assessment. (The Mental Health Day Treatment Functional Assessment, F-11090, must be signed and dated within three months of receipt by ForwardHealth.)

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12. Is the member's intellectual functioning below average?  Yes  No

If "yes," what is the member's IQ score or intellectual functioning level, and how was this measured?

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13. Provide a brief history pertinent to requested services. (Include psycho-social history, hospitalization history, family history, living situation history, etc.)

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14. Describe progress / status since treatment began or was last authorized, if applicable.

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**SECTION III — DOCUMENTATION (Continued)**

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15. Specify overall character of service to be provided.

- Rehabilitation       Maintenance       Stabilization

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16. Identify measurable treatment goals.

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17. Attach a specific schedule of activities, including date, time of day, length of session, and service to be provided.

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18. Estimate the member's rehabilitation potential for employment (competitive, supported, sheltered, etc.), social interaction, and independent living.

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**SECTION III — DOCUMENTATION (Continued)**

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I have read the attached requests for PA of adult mental health day treatment services and agree that it will be sent to ForwardHealth for review.

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**19. SIGNATURE** — Member or Representative

20. Date Signed

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21. Relationship (If Representative)

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**22. SIGNATURE** — Therapist Providing Treatment

23. Date Signed

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**24. SIGNATURE** — 51.42 Board Director / Designee (no longer required)

25. Date Signed (no longer required)

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