

**FORWARDHEALTH
PRIOR AUTHORIZATION AMENDMENT REQUEST**

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. Refer to the Prior Authorization Amendment Request Completion Instructions, F-11042A, for detailed information on completing this form.

SECTION I — MEMBER INFORMATION

1. Original PA Number	2. Process Type	3. Member Identification Number
4. Name — Member (Last, First, Middle Initial)		

SECTION II — PROVIDER INFORMATION

5. Billing Provider Number	7. Address — Billing Provider (Street, City, State, ZIP+4 Code)
6. Name — Billing Provider	

SECTION III — AMENDMENT INFORMATION

8. Requested Start Date	9. Requested End Date (If Different from Expiration Date of Current PA)
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10. Reasons for Amendment Request (Check All That Apply)

<input type="checkbox"/> Change Billing Provider Number	<input type="checkbox"/> Add Procedure Code / Modifier
<input type="checkbox"/> Change Procedure Code / Modifier	<input type="checkbox"/> Change Diagnosis Code
<input type="checkbox"/> Change Grant or Expiration Date	<input type="checkbox"/> Discontinue PA
<input type="checkbox"/> Change Quantity	<input type="checkbox"/> Other (Specify) _____

11. Description and Justification for Requested Change

12. Are Attachments Included? Yes No
If Yes, specify attachments below.

13. SIGNATURE — Requesting Provider	14. Date Signed — Requesting Provider
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