

**FORWARDHEALTH  
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)  
COMPLETION INSTRUCTIONS  
FOR RESIDENTIAL CARE CENTER TREATMENT SERVICES**

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 services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Providers may submit PA requests, along with all applicable service-specific attachments, F-11076A or F-11076B, to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I – PROVIDER INFORMATION**

**Element 1 – Name and Address – Provider**

Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. The name listed in this element must correspond with the National Provider Identifier listed in Element 4.

**Element 2 – Telephone Number – Billing Provider**

Enter the telephone number, including the area code, of the Residential Care Center.

**Element 3 – Processing Type**

Enter 126 – Psychotherapy (CMS 1500 billing providers only).

**Element 4 – Billing Provider National Provider Identifier**

Enter the National Provider Identifier of the billing provider.

**SECTION II – MEMBER INFORMATION**

**Element 5 – Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or the EVS to obtain the correct member ID.

**Element 6 – Date of Birth – Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 7 – Address – Member**

Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. Include the name of the residential care center.

**Element 8 – Name – Member**

Enter the member's last name, 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 spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

**Element 9 – Gender – Member**

Enter an "X" in the appropriate box to specify male or female.

**SECTION III – DIAGNOSIS AND TREATMENT INFORMATION**

**Element 10 – Diagnosis – Primary Code and Description**

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service requested.

**Element 11 – Start Date – SOI (not required)**

**Element 12 – First Date of Treatment – SOI (not required)**

**Element 13 – Diagnosis – Secondary Code and Description**

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service requested, if applicable.

**Element 14 – Requested Start Date**

Enter the requested start date for service (s) in MM/DD/CCYY format, if a specific start date is requested.

**Element 15 – Rendering Provider National Provider Identifier (not required)**

**Element 16 – Procedure Code**

Enter procedure code H0019.

**Element 17 – Modifiers**

Enter the appropriate modifier:

- |                               |                        |
|-------------------------------|------------------------|
| U1 – Standard Residential     | U5 – Medically Complex |
| U2 – Assessment               | U6 – Sex Offender      |
| U3 – Behavioral Stabilization | U7 – Boys              |
| U4 – Intensive Needs          | U8 – Girls             |

**Element 18 – POS**

Enter place of service 99.

**Element 19 – Description of Service**

Enter behavioral health; long term residential.

**Element 20 – QR**

Enter the number of days of service being requested.

For initial admissions to the RCC, the maximum number of days that can be requested and authorized is 365 (366 in leap years).

For unplanned readmissions within 90 days of discharge from the RCC, the number of days requested should be determined by the medical necessity of the services as stated in the member's treatment plan.

For children who are served in the RCC for intermittent services, the number of days requested should be calculated as the number of days the child is served in the RCC as determined by the medical necessity of the services as stated in the member's treatment plan.

**Element 21 – Charge**

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

*Note:* The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health Services.

**Element 22 – Total Charge**

Enter the anticipated total charge for this request.

**Element 23 – Signature – Requested Provider**

Enter the signature of the provider requesting this service.

**Element 24 – Date Signed**

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