

## FORWARDHEALTH PRIOR AUTHORIZATION / HEALTH AND BEHAVIOR INTERVENTION ATTACHMENT (PA/HBA) COMPLETION INSTRUCTIONS

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 (DHS 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 mandatory when requesting PA for certain services. 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.

Attach the completed Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA), F-11088, to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests electronically via the ForwardHealth Portal by accessing [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/), by fax to ForwardHealth at (608) 221-8616, or by mail to the following address:

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

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### INSTRUCTIONS

The information contained in the PA/HBA is used to make a decision about the amount and type of intervention that is approved for ForwardHealth reimbursement. Thoroughly complete each section and include any material that would be helpful to support the medical necessity of the services being requested. When noted in these instructions, material from personal records may be substituted for the information requested on the form. When substituting material from personal records, indicate the purpose of the materials.

Prior authorization for health and behavior interventions is not granted when another provider already has an approved PA for health and behavior intervention services for the same member. In these cases, ForwardHealth recommends that the member request that the other provider notify ForwardHealth that they have discontinued treatment with this member. The member may also submit a signed statement of his or her desire to change providers and include the date of the change. The new provider's PA may not overlap with the previous provider's PA.

### SECTION I — MEMBER INFORMATION

#### Element 1 — 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 identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Date of Birth — Member

Enter the date of birth of the member (in MM/DD/CCYY format).

#### Element 3 — Member Identification Number

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

## SECTION II — PROVIDER INFORMATION

### Element 4 — Name — Rendering Provider

Enter the name of the therapist who will be providing the treatment.

### Element 5 — Rendering Provider National Provider Identifier

Enter the National Provider Identifier of the rendering provider.

### Element 6 — Telephone Number — Rendering Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the rendering provider.

### Element 7 — Credentials — Rendering Provider

Enter the credentials of the therapist who will be providing treatment. The discipline should correspond with the name listed in Element 4.

## SECTION III — CLINICAL INFORMATION

### Element 8 — Physical Health Diagnosis Related to the Need for Health and Behavior Interventions

Enter the physical health diagnosis related to the need for health and behavior intervention services. Indicate the date the diagnosis was given and by whom.

### Element 9 — Biopsychosocial Factors Related to the Member's Physical Health Status

Enter a summary of the biopsychosocial factors resulting from the member's physical health diagnosis as discovered in the health and behavior assessment. Indicate the date of the health and behavior assessment.

### Element 10 — Treatment Modalities

Indicate the treatment modalities being implemented.

### Element 11 — Treatment Schedule

Enter the anticipated length of sessions, frequency of sessions, and duration of services requested on this PA. If requesting sessions more frequently than once per week, indicate why they are needed. If a series of treatments is anticipated (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment requested, the time period over which the treatment is requested, and the expected pattern of treatment. This quantity should match the quantity(ies) in Element 22 of the PA/RF. (Services at intensities lower than the average of one hour weekly may be approved for a duration of up to six months.)

### Element 12 — Member's Measurable Goals of Treatment Modalities

Indicate the member's measurable goals of each treatment modality being requested.

### Element 13 — Anticipated Duration of Treatment

Indicate the anticipated duration of treatment to address the issues related to the identified physical health diagnosis listed in Element 8.

### Element 14 — Signature — Rendering Provider

Enter the signature of the rendering provider.

### Element 15 — Date Signed

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