

**FORWARDHEALTH  
 PRIOR AUTHORIZATION / CARE PLAN ATTACHMENT (PA/CPA)**

**Instructions:** Print or type clearly. Refer to the Required Information for Prior Authorization/Care Plan Attachment (PA/CPA), Completion Instructions, F-11096A, for information about completing this form.

**SECTION I — MEMBER INFORMATION**

1a. Name — Member	1b. Telephone Number — Member
2. Member Identification Number	
3. Start of Care Date	4. Certification Period
	From <span style="float:right">To</span>

**SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED**

5. Principal Diagnosis ( <i>International Classification of Diseases, Ninth Revision, Clinical Modification</i> [ICD-9-CM] Code, Description, Date of Diagnosis)	6. Surgical Procedure and Other Pertinent Diagnoses (ICD-9-CM Code, Description, Date of Procedure or Diagnoses)
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**SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION**

7. Durable Medical Equipment	
8a. Functional Limitations 1 <input type="checkbox"/> Amputation      5 <input type="checkbox"/> Paralysis      9 <input type="checkbox"/> Legally Blind 2 <input type="checkbox"/> Bowel / Bladder (Incontinence)      6 <input type="checkbox"/> Endurance      10 <input type="checkbox"/> Dyspnea with Minimal Exertion 3 <input type="checkbox"/> Contracture      7 <input type="checkbox"/> Ambulation      11 <input type="checkbox"/> Other (Specify in Element 8b) 4 <input type="checkbox"/> Hearing      8 <input type="checkbox"/> Speech	8b. If "Other" checked in Element 8a, specify other functional limitations.
9a. Activities Permitted 1 <input type="checkbox"/> Complete Bedrest      6 <input type="checkbox"/> Partial Weight Bearing      10 <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP      7 <input type="checkbox"/> Independent at Home      11 <input type="checkbox"/> Walker 3 <input type="checkbox"/> Up As Tolerated      8 <input type="checkbox"/> Crutches      12 <input type="checkbox"/> No Restrictions 4 <input type="checkbox"/> Transfer Bed / Chair      9 <input type="checkbox"/> Cane      13 <input type="checkbox"/> Other (Specify in Element 9b) 5 <input type="checkbox"/> Exercises Prescribed	9b. If "Other" checked in Element 9a, specify other activities permitted.

10. Medications (Dose / Frequency / Route)

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11. Allergies

*Continued*



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**SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION (Continued)**

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12. Nutritional Requirements

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13. Mental Status    1  Oriented                    3  Forgetful                    5  Disoriented                    7  Agitated  
                                 2  Comatose                    4  Depressed                    6  Lethargic                    8  OtherÀ .....

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14. Prognosis            1  Poor                    2  Guarded                    3  Fair                    4  Good                    5  Excellent

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**SECTION IV — ORDERS**

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15. Orders for Services and Treatments (Number / Frequency / Duration)

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**SECTION IV — ORDERS (Continued)**

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16. Goals / Rehabilitation Potential / Discharge Plans

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**SECTION V — SUPPLEMENTARY MEDICAL INFORMATION**

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17. Date Physician Last Saw Member	18. Dates of Last Inpatient Stay Within 12 Months (If Known) <del>Admission</del> <del>Discharge</del>	19. Type of Facility for Last Inpatient Stay (If Applicable)
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20. Current Information (Summary from Each Discipline / Treatments / Clinical Facts)

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21. Home or Social Environment

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22. Medical and / or Nonmedical Reasons Member Regularly Leaves Home (Include Frequency)

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**SECTION V — SUPPLEMENTARY MEDICAL INFORMATION (Continued)**

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23. Names of Other Providers with Whom This Case Is Shared

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**SECTION VI — SIGNATURES**

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**Nurse Certification**

As the nurse completing this plan of care (POC), I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form.

24. **SIGNATURE** — Authorized Registered Nurse Completing Form

25. Date Signed by Authorized Registered Nurse Completing Form

26. Date of Verbal Orders for Initial Certification Period

27. Date Physician-Signed Form Received

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**Physician Certification**

The member is under my care, and I have ordered the services on this POC.

28. Name and Address — Attending Physician (Street, City, State, ZIP+4 Code)

29. **SIGNATURE** — Attending Physician

30. Date Signed — Attending Physician

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**Case Sharing Provider**

As a provider countersigning this POC, I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form.

31. **COUNTERSIGNATURE**

32. Date Countersigned

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Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

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