

FORWARDHEALTH PHARMACY SPECIAL HANDLING REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for 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 service.

The use of this form is mandatory; use an exact copy of this form. ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form. Refer to the ForwardHealth Online Handbook for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a reasonable judgment about the case.

Pharmacy providers are required to complete and sign the Pharmacy Special Handling Request, F-13074. Pharmacy providers submitting paper claims that require the Pharmacy Special Handling Request must submit the paper claim form with the Pharmacy Special Handling Request to the following address:

ForwardHealth
Pharmacy Special Handling Unit
Ste 20
6406 Bridge Rd
Madison WI 53784-0020

SECTION I — PROVIDER INFORMATION

Element 1 — National Provider Identifier

Enter the National Provider Identifier.

Element 2 — Telephone Number — Provider

Enter the telephone number, including the area code, of the provider.

Element 3 — ForwardHealth Program

Select the program in which the member is enrolled.

SECTION II — REASON FOR REQUEST (Choose one.)

Element 4 — Policy Review Request

Check the box to indicate that a claim review is required. Provide all information including reason for override or exception. Include the following information:

- Explanation of Benefits (EOB) number.
- Reason for policy override request.
- Any additional information.

Element 5 — Emergency Supply Request

Check the box to indicate that the original claim was denied for a PA requirement and that the provider is resubmitting the claim for reconsideration. Include the following information:

- Internal Control Number, if available.
- Reason for reconsideration.
- Any additional information.

SECTION III — CERTIFICATION

Element 6 — Signature — Pharmacist or Dispensing Physician

The pharmacy provider or dispensing physician is required to complete and sign this form.

Element 7 — Date Signed

Enter the month, day, and year the Pharmacy Special Handling Request was signed (in MM/DD/CCYY format).