

FORWARDHEALTH PRIOR AUTHORIZATION / SUBSTANCE ABUSE ATTACHMENT (PA/SAA) 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/Substance Abuse Attachment (PA/SAA), F-11032, 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/, by fax to ForwardHealth at (608) 221-8616, or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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 — MEMBER INFORMATION

Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use the 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 — Age — Member

Enter the age of the member in numerical form (e.g., 16, 21, 60).

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 and Credentials — Rendering Provider

Enter the name and credentials of the provider who will be providing treatment.

Element 5 — Rendering Provider's National Provider Identifier (NPI)

Enter the National Provider Identifier (NPI) of the rendering provider.

Element 6 — Telephone Number — Rendering Provider

Enter the rendering provider's telephone number, including area code.

SECTION III — TYPE OF TREATMENT REQUESTED

Element 7

Designate the type of treatment requested (e.g., primary intensive outpatient treatment, aftercare/follow-up service, or affected family member/codependency treatment). Identify the types of sessions, duration, and schedule. The total hours must match the quantities indicated in Element 22 of the PA/RF.

SECTION IV — DOCUMENTATION

Element 8

Indicate if the member was in primary substance abuse treatment in the last 12 months. If “yes,” provide date(s), problem(s), outcome, and provider of service.

Element 9

Enter the date of the most recent diagnostic evaluation(s) or medical examination(s), which includes diagnosis, summary of present medical findings, and medical history.

Element 10

Specify any diagnostic procedures employed.

Element 11

Provide current primary and secondary (refer to the current *Diagnostic and Statistical Manual of Mental Disorders*) codes and descriptions.

Element 12

Describe the member’s current clinical problems and relevant history. Include substance abuse history.

Element 13

Describe the member’s family situation. Describe how family issues are being addressed and if family members are involved in treatment. If family members are not involved in treatment, specify why not.

Element 14

Provide a detailed description of treatment objectives and goals.

Element 15

Describe expected outcome of treatment (include use of self-help groups, if appropriate).

SECTION V — SIGNATURES

Element 16 — Signature — Member or Representative (Optional)

Signature of the member or representative indicates the member has read the attached request for PA of substance abuse and agrees that it will be sent to ForwardHealth for review. The member’s signature is optional.

Element 17 — Date Signed

Enter the month, day, and year the PA/SAA is signed (in MM/DD/CCYY format) by the member or representative.

Element 18 — Relationship (If Representative)

When a representative signs on behalf of the member, include his or her relationship to the member.

Element 19 — Signature — Rendering Provider

ForwardHealth requires the rendering provider’s signature to process the PA request. Read the PA statement before dating and signing the attachment.

Element 20 — Date Signed

Enter the month, day, and year the PA/SAA is signed (in MM/DD/CCYY format) by the rendering provider.

Element 21 — Discipline of Rendering Provider

Enter the discipline of the rendering provider.

Element 22 — Rendering Provider's NPI

Enter the NPI of the rendering provider.

Element 23 — Signature — Supervising Provider

Signature required only if the rendering provider is not a physician or psychologist.

Element 24 — Date Signed

Enter the month, day, and year the PA/SAA was signed (in MM/DD/CCYY format) by the supervising provider, if applicable.

Other Information

Providers may attach copies of assessments, treatment summaries, treatment plans, or other documentation in response to the information requested on the form. Providers are responsible for ensuring that the information attached adequately responds to what is requested.

The attachment must be signed and dated by the provider requesting/providing the service.