**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.11(3), Wis. Admin. Code

F-11044 (07/2012)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / HOME HEALTH THERAPY ATTACHMENT (PA/HHTA)**

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at 608-221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Home Health Therapy Attachment (PA/HHTA) Completion Instructions, F-11044A.

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| **SECTION I — MEMBER INFORMATION** |
| 1. Name — Member (Last, First, Middle Initial)

      | 1. Age — Member

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| 1. Member Identification Number

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| **SECTION II — PROVIDER INFORMATION** |
| 1. Name and Credentials — Therapist

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| 1. Therapist’s National Provider Identifier (NPI)

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| 1. Telephone Number — Therapist

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| 1. Name — Referring / Prescribing Physician

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| 1. Referring / Prescribing Physician’s NPI

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| **SECTION III — DOCUMENTATION** |
| 1. Provide a brief history pertinent to the service(s) requested.
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| 1. Provide a description of the member’s diagnosis and problems as they pertain to the need for the therapy services requested. (Include the date of onset.)
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*Continued*

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| **SECTION III — DOCUMENTATION (Continued)** |
| 1. State member’s therapy history. (Indicate type / date / location for all types of therapy.)
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| **Service Area** | **Location** | **Date** | **Problem Treated** |
| Physical Therapy |       |       |       |
| Occupational Therapy |       |       |       |
| Speech and Language Pathology |       |       |       |
| 1. Indicate the date of initial evaluation. (Supply dates / tests used / results of additional evaluations.)
 |
| 1. Describe progress in measurable / functional terms since treatment was initiated or last authorized.

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| 1. Attach a plan of care indicating specific, measurable goals and procedures to meet those goals.
 |
| 1. Describe rehabilitation potential.
 |
| 1. **SIGNATURE** — Requesting Provider

      | 1. Date Signed

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