**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Health Care Access and Accountability Wis. Admin. Code § DHS 107.11(3)

F-11096 (08/15)

**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.

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| **SECTION I — MEMBER INFORMATION** | |
| 1. Name — Member | |
| 2. Telephone Number — Member | 3. Member Identification Number |
| 4. Start of Care Date | 5. Certification Period  From       To |
| **SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED** | |
| 6. Principal Diagnosis (*International Classification of Diseases* [ICD] Code, Description, Date of Diagnosis) | |
| 7. Surgical Procedure and Other Pertinent Diagnoses (ICD Code, Description, Date of Procedure or Diagnoses) | |
| **SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION** | |
| 8. Durable Medical Equipment | |
| 9. Functional Limitations  1  Amputation 2  Bowel / Bladder (Incontinence) 3  Contracture  4  Hearing 5  Paralysis 6  Endurance  7  Ambulation 8  Speech 9  Legally Blind  10  Dyspnea with Minimal Exertion 11  Other (Specify other functional limitations in the space provided.) | |
| 10. Activities Permitted  1  Complete Bedrest 2  Bedrest BRP 3  Up As Tolerated 4  Transfer Bed / Chair  5  Exercises Prescribed 6  Partial Weight Bearing 7  Independent at Home 8  Crutches  9  Cane 10  Wheelchair 11  Walker 12  No Restrictions  13  Other (Specify other activities permitted in the space provided.) | |

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| **SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION (Continued)** |
| 11. Medications (Dose / Frequency / Route) |
| 12. Allergies |
| 13. Nutritional Requirements |
| 14. Mental Status 1  Oriented 3  Forgetful 5  Disoriented 7  Agitated  2  Comatose 4  Depressed 6  Lethargic 8  Other |
| 15. Prognosis 1  Poor 2  Guarded 3  Fair 4  Good 5  Excellent |
| **SECTION IV — ORDERS** |
| 16. Orders for Services and Treatments (Number / Frequency / Duration) |

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| **SECTION IV — ORDERS (Continued)** | | |
| 17. Goals / Rehabilitation Potential / Discharge Plans | | |
| **SECTION V — SUPPLEMENTARY MEDICAL INFORMATION** | | |
| 18. Date Physician Last Saw Member | 19. Dates of Last Inpatient Stay Within 12 Months (If Known)  Admission       Discharge | 20. Type of Facility for Last Inpatient Stay (If Applicable) |
| 21. Current Information (Summary from Each Discipline / Treatments / Clinical Facts) | | |
| 22. Home or Social Environment | | |
| 23. Medical and / or Nonmedical Reasons Member Regularly Leaves Home (Include Frequency) | | |

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| **SECTION V — SUPPLEMENTARY MEDICAL INFORMATION (Continued)** | | |
| 24. Names of Other Providers with Whom This Case Is Shared | | |
| **SECTION VI — SIGNATURES** | | |
| **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. | | |
| 25. **SIGNATURE** — Authorized Registered Nurse (RN) Completing Form | | 26. Date Signed by Authorized RN Completing Form |
| 27. Date of Verbal Orders for Initial Certification Period | 28. Date Physician-Signed Form Received | |
| **Physician Certification**  The member is under my care, and I have ordered the services on this POC. | | |
| 29. Name and Address — Attending Physician (Street, City, State, ZIP+4 Code) | | |
| 30. **SIGNATURE** — Attending Physician | | 31. Date Signed — Attending Physician |
| **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. | | |
| 32. **COUNTERSIGNATURE** | | 33. Date Countersigned |
| 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. | | |