**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 Limitations1 [ ]  Amputation 2 [ ]  Bowel / Bladder (Incontinence) 3 [ ]  Contracture 4 [ ]  Hearing 5 [ ]  Paralysis 6 [ ]  Endurance 7 [ ]  Ambulation 8 [ ]  Speech 9 [ ]  Legally Blind10 [ ]  Dyspnea with Minimal Exertion 11 [ ]  Other (Specify other functional limitations in the space provided.)       |
| 10. Activities Permitted1 [ ]  Complete Bedrest 2 [ ]  Bedrest BRP 3 [ ]  Up As Tolerated 4 [ ]  Transfer Bed / Chair5 [ ]  Exercises Prescribed 6 [ ]  Partial Weight Bearing 7 [ ]  Independent at Home 8 [ ]  Crutches9 [ ]  Cane 10 [ ]  Wheelchair 11 [ ]  Walker 12 [ ]  No Restrictions13 [ ]  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. |