**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code §§ DHS 107.24(3), DHS 152.06(3)(h),

F-11030 (02/2024) DHS 153.06(3)(g), DHS 154.06(3)(g)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA)**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA) Instructions, F-11030A. Prescribers may refer to the Forms page of the ForwardHealth Portal at [www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/  
ForwardHealthCommunications.aspx?panel=Forms](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms)for the completion instructions.

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth through the Portal, by fax at 608-221-8616, or by mail to ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784.

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| **SECTION I – MEMBER INFORMATION** | | | |
| 1. Name – Member (Last, First, Middle Initial) | | | |
| 2. Age – Member | 3. Member ID Number | | |
| **SECTION II – PROVIDER INFORMATION** | | | |
| 4. Name – Prescribing Physician | | | |
| 5. National Provider Identifier – Prescribing Physician | | | |
| 6. Phone Number – Prescribing Physician | | 7. Phone Number – Dispensing Provider | |
| **SECTION III – SERVICE INFORMATION** | | | |
| 8. Describe the overall physical status of the member (mobility, self-care, strength, and coordination). | | | |
| 9. Describe the medical condition of the member as it relates to the equipment or item requested (for example, describe why the member needs this equipment). | | | |
| 10. Is the member able to operate the equipment or item requested?  Yes  No  If not, who will do this? | | | |
| 11. Is training provided?  Yes  No  If yes, who will do this? | | | |
| If no, explain why training is not required. | | | |
| 12. State where equipment or item will be used. (Choose all that apply.)  Home  Job  Nursing Home  Office  School  Describe the accessibility of the places where the equipment will be used. | | | |
| 13. State estimated duration of need. | | | |
| 14. If renewal or continuation of DME authorization is requested, provide an update on the member’s condition since the implementation of the prescribed item(s). | | | |
| 15. Indicate amount of oxygen to be administered.        Liters per minute       Continuous        Hours per day       PRN        Days per week       PaO2 | | | |
| Attach a photocopy of the physician’s prescription to this attachment. The prescription must be signed and dated within one year of receipt by ForwardHealth. | | | |
| 16. **SIGNATURE** – Requesting Provider | | | 17. Date Signed |