

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

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

ForwardHealth members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. Per Wis. Admin. Code § DHS 104.02(4), this information should include information concerning enrollment status, accurate name, address, and member ID number.

Under Wis. Stat. § 49.45(4), 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 service. The use of this form is mandatory when requesting PA for durable medical equipment (DME).

INSTRUCTIONS

Per Wis. Admin. Code § DHS 106.02(9)(e), the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests. The provider is responsible for submitting sufficient information to support the medical necessity of the requested equipment or supplies. If the space provided is not sufficient, attach additional pages for the provider's responses and/or an occupational or physical therapy report if available. All DME, including repairs, must be prescribed by a physician. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements.

Attach a photocopy of the physician's prescription to the completed Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA) form, F-11030. The prescription must be signed and dated within one year of receipt by ForwardHealth. Attach the PA/DMEA form 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 through the ForwardHealth Portal, 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, followed by their first name and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or the spelling of the name on the ForwardHealth ID 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 (for example, 16, 21, 60).

Element 3: Member ID Number

Enter the member ID. Do not enter any other numbers or letters.

SECTION II – PROVIDER INFORMATION

Element 4: Name – Prescribing Physician

Enter the name of the prescribing physician.

Element 5: National Provider Identifier – Prescribing Physician

Enter the National Provider Identifier (NPI) of the prescribing physician. The NPI in this element must correspond with the provider name listed in Element 4.

Element 6: Phone Number – Prescribing Physician

Enter the prescribing physician's phone number, including area code.

Element 7: Phone Number – Dispensing Provider

Enter the dispensing provider's phone number, including area code.

SECTION III – SERVICE INFORMATION

Element 8

Describe the overall physical status of the member (mobility, self-care, strength, and coordination).

Element 9

Describe the medical condition of the member as it relates to the equipment or item requested. Indicate why the member needs this equipment.

Element 10

Indicate whether or not the member is able to operate the equipment or item requested. If not, list who will operate the equipment or item requested.

Element 11

Indicate whether or not training is provided or required. If yes, list who will provide the training. If not, explain why training is not required.

Element 12

State where equipment or item will be used. Describe the accessibility of the places where the equipment will be used.

Element 13

State estimated duration of need.

Element 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).

Element 15

Indicate amount of oxygen to be administered.

Element 16: Signature – Requesting Provider

Enter the signature of the requesting provider.

Element 17: Date Signed

Enter the month, day, and year the PA/DMEA was signed (in mm/dd/ccyy format).

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.