FORWARDHEALTH

PRIOR AUTHORIZATION / VISION ATTACHMENT (PA/VA) 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, but is not limited to, 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 certain procedures/services/items.

The completed Prior Authorization/Vision Services Attachment (PA/VA), F-11051, must be sent along with the Prior Authorization Request Form (PA/RF), F-11018, to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests via the ForwardHealth Portal at www.forwardhealth.wi.gov, 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 first name and middle initial. Use Wisconsin's Enrollment Verification System 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 Enrollment Verification System do not match, use the spelling from the Enrollment Verification System.

Element 2: Member ID Number
Enter the member ID. Do not enter any other numbers or letters.

Element 3: Date of Birth – Member
Enter the member's date of birth in mm/dd/ccyy format.

SECTION II – PROVIDER INFORMATION

Element 4: Name – Referring / Prescribing Provider
Enter the name of the referring/prescribing provider, if available.

Element 5: National Provider Identifier
Enter the National Provider Identifier of the referring/prescribing provider, if available.

Element 6: Phone Number – Referring / Prescribing Provider
Enter the referring/prescribing provider's phone number, including area code.

Element 7: Name – Contact Person
Enter the name of the person who should be contacted with questions about this PA request.

Element 8: Phone Number – Contact Person
Enter the phone number, including area code, of the person who should be contacted with questions about this PA request.

SECTION III – DOCUMENTATION

Element 9: Lenses and Frames
Complete frame information and lens formula is required for all requests for frames and lenses.

Check the appropriate box to indicate whether the prescriber is requesting a lens replacement only, a frame replacement only, or a complete appliance (lenses and frames). Enter the lens formula written in minus cylinder. Enter the frame name and frame manufacturer.

Element 10: Noncontract Items
Noncontract items require submission of a manufacturer's price list or lab invoice.

Check the box if the prescriber is requesting a noncontract frame (not supplied by the member). If the box is checked, provide justification for the noncontract frame. (The principal justification may not be cosmetic and must be medically/visually necessary.) Check the box if the prescriber is requesting noncontract lenses. If the box is checked, provide pertinent history/findings and justification, along with the specifics of the request. If the request is for contact lenses, provide the number of lenses for each eye and the length of time for the supply.

Element 11: Type of Tint
All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider. A diagnosis of photophobia, without substantiation, is insufficient justification.

List information regarding lens tint. Provide justification for lens tint.

Element 12: Other Vision Services Requested
Indicate any other vision services requested, including a description of the services requested, pertinent history/findings, and justification.

SECTION IV – AUTHORIZED SIGNATURE

Element 13: Signature – Requesting / Rendering Provider
Enter the signature of the requesting/rendering provider.

Element 14: Date Signed
Enter the month, day, and year the PA/VA was signed in mm/dd/ccyy format.