**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.02(3)

F-02815 (04/2022)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION FOR HOSPITAL PROLONGED STAY**

**INSTRUCTIONS:** Type or print clearly.

This form may be used to request prior authorization (PA) for a prolonged stay when a ForwardHealth member requires nursing facility level care after a hospital discharge but for whom the hospital is unable to locate a suitable facility.

A PA request may be approved for a maximum of 14 days. The hospital must resubmit a PA request for stays longer than 14 days.

**SUBMITTING PA REQUESTS:** Attach this form to requested records below and the Prior Authorization for Hospital Prolonged Stay Fax Cover Sheet, F-02815A, and submit them by fax to ForwardHealth at **608‑266-1096**.

|  |  |  |
| --- | --- | --- |
| 1. Name – Member (Last, First, Middle Initial) | | |
|  | | |
| 2. Member ID Number | 3. Type of PA Request | |
|  | Initial  Renewal | |
| 4. Name – Hospital or Critical Access Hospital | | |
|  | | |
| 5. National Provider Identifier – Hospital | 6. Requested Start Date | |
|  |  | |
| By my signature below, I hereby attest that I am supplying the following information as part of this PA request and that it is accurate and follows ForwardHealth guidelines to the best of my knowledge:   * An updated plan of care * Physician, physician assistant, or nurse practitioner order indicating level of care * Case management notes that include documentation of the following: * Reasons discharge from the hospital cannot be completed * Up to three referrals attempted or reasons why referrals were not attempted * The hospital’s plan to discharge the patient to a suitable facility as soon as practicable and medically appropriate | | | |
| 7. **SIGNATURE** –Physician | | 8. Date Signed (mm/dd/ccyy) |