

**FORWARDHEALTH
 PRIOR AUTHORIZATION / THERAPY ATTACHMENT (PATA)**

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Therapy Attachment (PA/TA) Completion Instructions, F-11008A.

SECTION I — MEMBER / PROVIDER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Member Identification Number	3. Age — Member
4. Name and Credentials — Therapist	5. Therapist's National Provider Identifier	6. Telephone No. — Therapist
7. Name — Referring / Prescribing Physician	8. Requesting PA for <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech and Language Pathology	
9. Total Time Per Day Requested	10. Total Sessions Per Week Requested	
11. Total Number of Weeks Requested	12. Requested Start Date	

SECTION II — PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

13. Provide a description of the member's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

SECTION III — BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

14. Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

SECTION IV — PERTINENT THERAPY INFORMATION

15. Document the chronological history of treatment provided for the diagnoses (identified under Section II), dates of those treatments, and the member's functional status following those treatments.

Provider Type (e.g., occupational therapy, physical therapy, speech and language pathology)	Dates of Treatment	Functional Status After Treatment

Continued



SECTION IV — PERTINENT THERAPY INFORMATION (Continued)

16. List other service providers that are currently accessed by the member for those treatment diagnoses identified under Section II (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include telephone logs, summarization of conversations or written communication, copies of plans of care, staffing reports, or received written reports.

17. Check the appropriate box and circle the appropriate form, if applicable.

- The current Individualized Education Program (IEP) / Individualized Family Service Plan (IFSP) / Individual Program Plan (IPP) is attached to this PA request.
- The current IEP / IFSP / IPP is attached to PA number _____.
- There is no IEP / IFSP / IPP because _____.
- Cotreatment with another therapy provider is within the plan of care.
- Referenced report(s) is attached (list any report[s]) _____.

SECTION V — EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE A BASELINE FOR THE MEMBER'S FUNCTIONAL LIMITATIONS)

18. Attach a copy of the initial evaluation or the most recent evaluation or re-evaluation, **or** indicate with which PA number this information was previously submitted.

- Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.
- Comprehensive initial evaluation submitted with PA number _____.
- Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.
- Current re-evaluation submitted with PA number _____.

SECTION VI — PROGRESS

19. Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals / limitations, *since treatment was initiated or last authorized*.

Goal / Limitation	Previous Status / Date	Status as of Date of PA Request / Date
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(If this information is concisely written in other documentation prepared for the provider's/therapist's records, attach and write "see attached" in the space above.)

Continued

SECTION VII — PLAN OF CARE

20. Identify the specific, measurable, objective, and functional goals for the member (to be met by the end of this PA request) and both of the following:
- (1) Indicate the therapist-required skills / treatment techniques that will be used to meet each goal.
 - (2) Designate (with an asterisk [*]) which goals are reinforced in a carry-over program.

(If the plan of care is concisely written in other documentation prepared for the member's records, attach and write "see attached" in the space above.)

SECTION VIII — REHABILITATION POTENTIAL

21. Complete the following sentences based upon the professional assessment.

(1) Upon discharge from this episode of care, the member will be able to

(2) Upon discharge from this episode of care, the member may continue to (list supportive services)

(3) The member / member's caregivers support the therapy plan of care by the following activities and frequency of carryover

(4) It is estimated this episode of care will end (provide approximate end time)

22. **SIGNATURE** — Providing Therapist

23. Date Signed

24. **SIGNATURE** — Member or Member Caregiver (optional)

25. Date Signed
