FORWARDHEALTH
PRIOR AUTHORIZATION / PHYSICIAN OTOLOGICAL REPORT (PA/POR) COMPLETION INSTRUCTIONS

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

Members of the ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., 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 Prior Authorization/Physician Otological Report (PA/POR), F-11019, is mandatory when a hearing instrument specialist requires PA for a hearing instrument. Audiologists may use the PA/POR in place of a physician prescription, which is to be kept in the member's medical record. Upon completion, give one copy to the member to take the testing center and retain a second copy for your files.

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s). Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Physician
Enter the name of the requesting physician.

Element 2 — Physician's National Provider Identifier
Enter the National Provider Identifier of the physician.

Element 3 — Address — Physician
Enter the address (street, city, state, ZIP+4 code) of the requesting physician.

Element 4 — Telephone Number — Physician
Enter the telephone number, including area code, of the requesting physician.

SECTION II — MEMBER INFORMATION

Element 5 — Name — Member
Enter the member's last name, followed by his or her 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 spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 6 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 7 — Address — Member
Enter the complete address (street, city, state, and ZIP+4 code) of the member's place of residence. If the member is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 8 — Member Identification Number
Enter the member's ID number. Do not enter any other numbers or letters.

Element 9 — Gender — Member
Enter an "X" in the appropriate box.

SECTION III — DOCUMENTATION

Element 10 — Medical History of Hearing Loss
Enter the member's medical history of hearing loss (if any).

Element 11 — Pertinent Otological Findings
Enter an "X" in the appropriate box(es) and describe all problems.

Element 12 — Additional Findings
Describe any additional findings not covered in Element 11.

Element 13 — Clinical Diagnosis of Hearing Status
Enter the diagnosis of the member's hearing status.

Element 14 — Medical, Cognitive, or Developmental Problems
Describe any medical, cognitive, or developmental problems of the member.

Element 15 — Physician's Recommendations
Enter an 'X' in the appropriate box(es) to indicate the physician's recommendations.

Signature — Physician and Date Signed
The requesting physician must sign the form and enter the date the request is made.