**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.15(3), Wis. Admin. Code

F-11029 (07/2012)

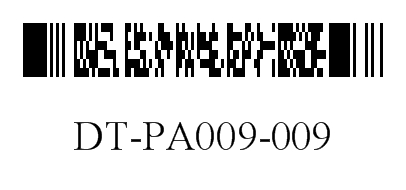
**FORWARDHEALTH**

**PRIOR AUTHORIZATION / CHIROPRACTIC ATTACHMENT (PA/CA)**

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/Chiropractic Attachment (PA/CA) Completion Instructions, F-11029A.

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| **SECTION I — PROVIDER INFORMATION** | | |
| 1. Name — Provider | | |
| 2. Address — Clinic or Office Where Service(s) Is Provided | | |
| 3. National Provider Identifier | 4. Telephone Number — Provider | |
| **SECTION II — MEMBER INFORMATION** | | |
| 5. Name — Member (Last, First, Middle Initial) | | 6. Date of Birth — Member |
| 7. Member Identification Number | | |
| **SECTION III — SERVICE INFORMATION** | | |
| 8. Total Number of Services Requested (Specify) | 9. Total Number of Weeks Requested | |
| 10. Requested Start Date of Prior Authorization | | |
| **SECTION IV — SUPPORTING INFORMATION** | | |
| 11. Date of Spell of Illness | 12. Date of Beginning Treatment | |
| 13. History  a) Initial  b) Spell of Illness  c) Previous and / or Concurrent Care | | |

*Continued*



**PRIOR AUTHORIZATION / CHIROPRACTIC ATTACHMENT (PA/CA)** Page 2 of 2

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| **SECTION IV — SUPPORTING INFORMATION (Continued)** | |
| 14. Subjective Complaints  a) Initial  b) Spell of Illness | |
| 15. Objective Findings  a) Initial  b) Spell of Illness  c) Diagnosis | |
| 16. Subjective Progress | |
| 17. Objective Progress | |
| 18. Prognosis / Treatment Plan | |
| 19. Additional Comments | |
| 20. **SIGNATURE** — Examining / Treating Provider | 21. Date Signed |