**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. Historya) Initial      b) Spell of Illness      c) Previous and / or Concurrent Care       |

*Continued*



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

F-11029 (07/2012)

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| **SECTION IV — SUPPORTING INFORMATION (Continued)** |
| 14. Subjective Complaintsa) Initial      b) Spell of Illness       |
| 15. Objective Findingsa) 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       |