**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.13(2), Wis. Admin. Code

F-11031 (07/2012)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / PSYCHOTHERAPY ATTACHMENT (PA / PSYA)**

Providers may submit prior authorization (PA) requests 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/Psychotherapy Attachment (PA/PSYA) Completion Instructions, F-11031A. Failure to complete all elements could result in return or denial of PA request. Attach a copy of the member’s assessment and treatment/recovery plan. Providers may submit this information on a new optional form, the Outpatient Mental Health Assessment and Treatment/Recovery Plan, F-11103.

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| **SECTION I — MEMBER INFORMATION** | | | |
| 1. Name — Member (Last, First, Middle Initial) | 1. Date of Birth — Member | 1. Member Identification Number | |
| **SECTION II — PROVIDER INFORMATION** | | | |
| 1. Name and Address — Rendering Provider | 1. Rendering Provider’s National Provider Identifier | | |
| 1. Telephone Number — Rendering Provider | 1. Discipline — Rendering Provider | | |
| **SECTION III — SERVICE REQUEST**  Based on the information in the member’s assessment and treatment/recovery plan or recorded on the optional Department of Health Services Outpatient Mental Health Assessment and Treatment/Recovery Plan, the following services are requested. | | | |
| 8. Number of Minutes Per Session  Individual       Group       Family       Other | | | |
| 9. Frequency of Requested Sessions (Services in excess of once weekly require specific justification.)  Monthly       Twice / month       Once / week       Other | | | |
| 10. Total Number of Sessions / Hours Requested for This PA Period | | | |
| 11. Treatment Approach | | | |
| 12. Estimated Termination Date | | | |
| 13.  **SIGNATURE** — Rendering Provider | | | 14. Date Signed |