**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.13, Wis. Admin. Code

F-11033 (07/2012)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / MENTAL HEALTH AND / OR SUBSTANCE ABUSE EVALUATION ATTACHMENT (PA/EA)**

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/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA) Completion Instructions, F-11033A. Failure to complete all elements could result in return or denial of PA requests.

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| **SECTION I — MEMBER INFORMATION** | | |
| 1. Name — Member (Last, First, Middle Initial) | 2. Date of Birth — Member | 3. Member Identification Number |
| **SECTION II — PROVIDER INFORMATION** | | |
| 4. Name —Rendering Provider | 5. Rendering Provider National Provider Identifier | |
| 1. Telephone Number — Rendering Provider | 1. Discipline — Rendering Provider | |

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| **SECTION III — DOCUMENTATION** | |
| 8. Indicate the type of evaluation being requested and why this evaluation is needed. If this was a referral, indicate who made the referral. Be specific as to how the member will benefit from this evaluation. (Do not include Central Nervous Assessments [*Current Procedural Terminology* procedure codes 96101-96120] in this request.) | |
| 9. Indicate other evaluations the provider is aware of that have been conducted on this member in the past two years. Indicate why the requested evaluation does not duplicate earlier evaluations. | |
| **10. SIGNATURE** —Rendering Provider | 11. Date Signed |

