**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.13(3m), Wis. Admin. Code

F-11037 (07/2012)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA)**

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/Substance Abuse Day Treatment Attachment (PA/SADTA) Completion Instructions, F-11037A.

|  |  |
| --- | --- |
| **SECTION I — MEMBER INFORMATION** | |
| 1. Name — Member (Last, First, Middle Initial) | 2. Age — Member |
| 3. Member Identification Number | |
| **SECTION II — PROVIDER INFORMATION** | |
| 4. Name and Credentials — Requesting / Rendering Provider | |
| 5. Telephone Number — Requesting / Rendering Provider | |
| **SECTION III — DOCUMENTATION** | |
| 6. Describe length and intensity of treatment requested.   * Program request is for       hours per day,         days per week,  for       weeks,  for a total of       hours.   * Anticipated beginning treatment date      . * Estimated substance abuse day treatment discharge date      . * Attach a copy of treatment design, which includes the following:  1. A schedule of treatment (day, time of day, length of session, and service to be provided during that time). 2. A brief description of aftercare / continuing care / follow-up component (also include this information in the treatment plan section of this form). | |
| 7. List the dates of diagnostic evaluations or medical examinations and **specific** diagnostic procedures that were employed. | |

*Continued*

**PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA)** Page 2 of 4

F-11037 (07/2012)

|  |
| --- |
| **SECTION III — DOCUMENTATION (Continued)** |
| 8. List the **current** primary and secondary diagnosis codes and descriptions from the most recent *Diagnostic and Statistical Manual of Mental Disorders* for the member’s current primary and secondary diagnosis. |
| 9. Describe the member’s **current** clinical problems and relevant clinical history, including substance abuse history. (Give details of dates of abuse, substance[s] abused, amounts used, date of last use, etc.) |
| 10. Has the member received any substance abuse treatment in the past 12 months?  Yes  No  If “Yes,” provide information on the date of each treatment episode, the type of service provided, and the **treatment outcomes**. |
| 11. Has the member received any inpatient substance abuse care, intensive outpatient  substance abuse services, or substance abuse day treatment in the past 12 months?  Yes  No  If “Yes,” give rationale for appropriateness and medical necessity of the current request. Describe projected outcome of additional treatment requested. |

*Continued*

**PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA)** Page 3 of 4

F-11037 (07/2012)

|  |
| --- |
| **SECTION III — DOCUMENTATION (Continued)** |
| 12. Describe the member’s severity of illness using the following indicators. Individualize all information.   1. Loss of control / relapse crisis. |
| 1. Physical conditions or complications. |
| 1. Psychiatric conditions or complications. (Include psychiatric diagnosis, medications, current psychiatric symptoms.) |
| d. Recovery environment. |
| e. Life areas impairment. (Specify social / occupational / legal / primary support group.) |
| 1. Treatment acceptance / resistance. |
| 1. Treatment Plan  * **Attach** a copy of the member’s substance abuse day treatment plan (refer to intensity of service guideline in the substance abuse day treatment criteria). * Describe any special needs of the member and indicate how these will be addressed (for example, educational needs, access to treatment facility). * Describe the member’s family / personal support system. Indicate how these issues will be addressed in treatment, if applicable. If family members / personal support system are not involved in treatment, explain why not. |

*Continued*

**PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA)** Page 4 of 4

F-11037 (07/2012)

|  |  |
| --- | --- |
| **SECTION III — DOCUMENTATION (Continued)** | |
| 13. Treatment Plan (Continued)   * Briefly describe treatment goals and objectives in specific and measurable terms. * Describe the expected outcomes of treatment including the plan for continuing care. | |
| I have read the attached request for PA of substance abuse day treatment services and agree that it will be sent to ForwardHealth for review. | |
| **14. SIGNATURE** — Member or Representative | 15. Date Signed |
| 16. Relationship (If Representative) | |
| **17. SIGNATURE** — Rendering Provider | 18. Date Signed |
| 19. Discipline of Rendering Provider | |
| **20. SIGNATURE** — Supervising Physician or Psychologist | 21. Date Signed |
| 22. Supervising Physician or Psychologist’s NPI | |