**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.13(4), Wis. Admin. Code

F-11038 (07/2012)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / ADULT MENTAL HEALTH DAY TREATMENT ATTACHMENT (PA/AMHDTA)**

Providers may submit prior authorization (PA) requests by fax to ForwardHealth 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/Adult Mental Health Day Treatment Attachment (PA/AMHDTA) Completion Instructions, F-11038A.

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| **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. Requesting / Rendering Provider’s National Provider Identifier (NPI) | 6. Telephone Number — Requesting / Rendering Provider | |
| **SECTION III — DOCUMENTATION** | | |
| 7. Number of Hours per Week Requested | 8. Estimated Final Treatment Date | |
| 9. Has the member had previous adult mental health day treatment at the provider’s facility or elsewhere?  Yes  No  Unknown  If “yes,” list dates and locations. | | |
| 10. Evaluation(s) (Include date[s], tests used, and results.) | | |

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| **SECTION III — DOCUMENTATION (Continued)** |
| 11. Attach Section I of the member’s most recent Functional Assessment. (The Mental Health Day Treatment Functional Assessment, F-11090, must be signed and dated within three months of receipt by ForwardHealth.) |
| 12. Is the member’s intellectual functioning below average? Yes No  If “yes,” what is the member’s IQ score or intellectual functioning level, and how was this measured? |
| 13. Provide a brief history pertinent to requested services. (Include psycho-social history, hospitalization history, family history, living situation history, etc.) |
| 14. Describe progress / status since treatment began or was last authorized, if applicable. |

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| **SECTION III — DOCUMENTATION (Continued)** |
| 15. Specify overall character of service to be provided.  Rehabilitation  Maintenance  Stabilization |
| 16. Identify measurable treatment goals. |
| 17. Attach a specific schedule of activities, including date, time of day, length of session, and service to be provided. |
| 18. Estimate the member’s rehabilitation potential for employment (competitive, supported, sheltered, etc.), social interaction, and independent living. |

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| **SECTION III — DOCUMENTATION (Continued)** | |
| I have read the attached requests for PA of adult mental health day treatment services and agree that it will be sent to ForwardHealth for review. | |
| **19. SIGNATURE** — Member or Representative | 20. Date Signed |
| 21. Relationship (If Representative) | |
| **22. SIGNATURE** — Therapist Providing Treatment | 23. Date Signed |
| **24. SIGNATURE —** 51.42 Board Director / Designee (no longer required) | 25. Date Signed (no longer required) |