# DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN

Division of Medicaid Services DHS 106.03(4), Wis. Admin. Code

F-11042 (07/2012) DHS 152.06(3(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

**FORWARDHEALTH**

### PRIOR AUTHORIZATION AMENDMENT REQUEST

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. Refer to the Prior Authorization Amendment Request Completion Instructions, F-11042A, for detailed information on completing this form.

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| SECTION I — MEMBER INFORMATION |
| 1. Original PA Number

      | 1. Process Type

      | 1. Member Identification Number

      |
| 1. Name — Member (Last, First, Middle Initial)

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| **SECTION II — PROVIDER INFORMATION** |
| 1. Billing Provider Number

      | 1. Address — Billing Provider (Street, City, State, ZIP+4 Code)

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| 1. Name — Billing Provider

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| **SECTION III — AMENDMENT INFORMATION** |
| 1. Requested Start Date

      | 1. Requested End Date (If Different from Expiration Date of Current PA)

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| 10. Reasons for Amendment Request (Check All That Apply) [ ]  Change Billing Provider Number [ ]  Add Procedure Code / Modifier [ ]  Change Procedure Code / Modifier [ ]  Change Diagnosis Code [ ]  Change Grant or Expiration Date [ ]  Discontinue PA [ ]  Change Quantity [ ]  Other (Specify)        |
| 11. Description and Justification for Requested Change       |
| 12. Are Attachments Included? [ ] Yes [ ]  No If Yes, specify attachments below.       |
| 13. **SIGNATURE** — Requesting Provider      | 14. Date Signed — Requesting Provider      |

