# 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) | | | | |
| **SECTION II — PROVIDER INFORMATION** | | | | |
| 1. Billing Provider Number | | 1. Address — Billing Provider (Street, City, State, ZIP+4 Code) | | |
| 1. Name — Billing Provider | |
| **SECTION III — AMENDMENT INFORMATION** | | | | |
| 1. Requested Start Date | | 1. Requested End Date (If Different from Expiration Date of Current PA) | | |
| 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 |

