**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.11(3), Wis. Admin. Code

F-11044 (07/2012)

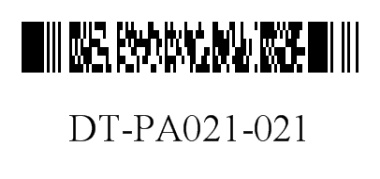
**FORWARDHEALTH**

**PRIOR AUTHORIZATION / HOME HEALTH THERAPY ATTACHMENT (PA/HHTA)**

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. Before completing this form, read the Prior Authorization/Home Health Therapy Attachment (PA/HHTA) Completion Instructions, F-11044A.

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| **SECTION I — MEMBER INFORMATION** | |
| 1. Name — Member (Last, First, Middle Initial) | 1. Age — Member |
| 1. Member Identification Number | |
| **SECTION II — PROVIDER INFORMATION** | |
| 1. Name and Credentials — Therapist | |
| 1. Therapist’s National Provider Identifier (NPI) | |
| 1. Telephone Number — Therapist | |
| 1. Name — Referring / Prescribing Physician | |
| 1. Referring / Prescribing Physician’s NPI | |
| **SECTION III — DOCUMENTATION** | |
| 1. Provide a brief history pertinent to the service(s) requested. | |
| 1. Provide a description of the member’s diagnosis and problems as they pertain to the need for the therapy services requested. (Include the date of onset.) | |

*Continued*

**PRIOR AUTHORIZATION / HOME HEALTH THERAPY ATTACHMENT (PA/HHTA)** Page 2 of 2

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| **SECTION III — DOCUMENTATION (Continued)** | | | | |
| 1. State member’s therapy history. (Indicate type / date / location for all types of therapy.) | | | | |
| **Service Area** | **Location** | **Date** | | **Problem Treated** |
| Physical Therapy |  |  | |  |
| Occupational Therapy |  |  | |  |
| Speech and Language Pathology |  |  | |  |
| 1. Indicate the date of initial evaluation. (Supply dates / tests used / results of additional evaluations.) | | | | |
| 1. Describe progress in measurable / functional terms since treatment was initiated or last authorized. | | | | |
| 1. Attach a plan of care indicating specific, measurable goals and procedures to meet those goals. | | | | |
| 1. Describe rehabilitation potential. | | | | |
| 1. **SIGNATURE** — Requesting Provider | | | 1. Date Signed | |