**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.20(2)

F-11051 (10/2020)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / VISION SERVICES ATTACHMENT (PA/VA)**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Vision Services Attachment (PA/VA) Instructions, F-11051A.

Providers may submit prior authorization 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.

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| **SECTION I – MEMBER INFORMATION** | | | | | | | | |
| 1. Name – Member (Last, First, Middle Initial) | | | | | | | | |
| 2. Member ID Number | | | | | 3. Date of Birth – Member | | | |
| **SECTION II – PROVIDER INFORMATION** | | | | | | | | |
| 4. Name – Referring / Prescribing Provider | | | | | | | | |
| 5. National Provider Identifier | | | | | 6. Phone Number – Referring / Prescribing Provider | | | |
| 7. Name – Contact Person | | | | | 8. Phone Number – Contact Person | | | |
| **SECTION III – DOCUMENTATION** | | | | | | | | |
| 9. Lenses and Frames (Complete frame information and lens formula is required for all requests for frames and lenses.)  Lens Replacement Only  Frame Replacement Only  Complete Appliance (Lenses and Frames)  Lens Formula (Written in Minus Cylinder) | | | | | | | | |
| **Rx** | **SPH** | **CYL** | **AXIS** | **PRISM** | | **ADD** | | **LENS MATERIAL** |
| **O.D.** |  |  |  |  | |  | |  |
| **O.S.** |  |  |  |  | |  | |  |
| Frame Name | | | | | Frame Manufacturer | | | |
| 10. Noncontract Items (Requires Submission of a Manufacturer’s Price List or Lab Invoice)  Noncontract Frame (Not Supplied by Member)  Justification for noncontract frame (The principal justification may not be cosmetic and must be medically/visually necessary.) | | | | | | | | |
| Noncontract Lenses  Provide pertinent history/findings and justification, along with the specifics of the request. If the request is for contact lenses, provide the number of lenses for each eye and the length of time for the supply. | | | | | | | | |
| 11. Type of Tint(All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider. A diagnosis of photophobia, without substantiation, is insufficient justification.)    Justification for Tint | | | | | | | | |
| 12. Other Vision Services Requested (Include a description of services requested, pertinent history/findings, and justification.) | | | | | | | | |
| **SECTION IV – AUTHORIZED SIGNATURE** | | | | | | | | |
| 13. **SIGNATURE** –Requesting / Rendering Provider | | | | | | | 14. Date Signed | |