

FORWARDHEALTH PRIOR AUTHORIZATION / VISION ATTACHMENT (PA/VA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when requesting prior authorization for certain procedures/services/items.

The completed Prior Authorization/Vision Services Attachment (PA/VA), F-11051, must be sent along with the Prior Authorization Request Form (PA/RF), F-11018, to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests via the ForwardHealth Portal at www.forwardhealth.wi.gov/, by fax to ForwardHealth at (608) 221-8616, or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member

Enter the member's last name, followed by his or her first name and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or the spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Member

Enter the age of the member in numerical form (e.g., 16, 21, 60).

Element 3 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Referring / Prescribing Provider

Enter the name of the referring/prescribing provider, if available.

Element 5 — Referring / Prescribing Provider National Provider Identifier

Enter the National Provider Identifier of the referring/prescribing provider, if available.

Element 6 — Telephone Number — Referring / Prescribing Provider

Enter the referring/prescribing provider's telephone number, including area code.

SECTION III — DOCUMENTATION

Element 7 — Lenses and Frames

List information regarding lenses and frames. Lens formula information written in minus cylinder form is required for all requests for frames and lenses.

Element 8 — Special Lens / Frame Request

List information regarding special lens/frame request. Lens formula information is required for all requests for frames and lenses.

Element 9 — Tints

List information regarding lens tint. All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider.

Element 10 — Other Vision Services Requested

Indicate any other vision services requested, including a description of the services requested, pertinent history/findings, and justification.

Element 11 — Signature — Rendering Provider

Enter the signature of the requesting/rendering provider.

Element 12 — Date Signed

Enter the month, day, and year the PAVA was signed (in MM/DD/CCYY format).