FORWARDHEALTH

PRIOR AUTHORIZATION / OXYGEN ATTACHMENT (PA/OA)

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/Oxygen Attachment (PA/OA) Completion Instructions, F-11066A. Providers are required to attach a completed Record of Actual Daily Oxygen Use form, F-11067, or a copy of the member's oxygen use records to the PA/OA for members who reside in a nursing home.

SECTION I — PROVIDER INFORMATION

1. Name — Medical Equipment Vendor	2. Medical Equipment Vendor's National Provider Identifier (NPI)
3. Telephone Number — Medical Equipment Vendor	4. Requested Start Date
5. Name — Person Completing Form	6. Title — Person Completing Form
7. Name — Prescribing Physician	8. Prescribing Physician's NPI
9. Address — Prescribing Physician (Street, City, State, and ZIP+4 Code)	10. Telephone Number — Prescribing Physician

SECTION II — MEMBER INFORMATION

11. Name — Member (Last, First, Middle Initial)	12. Member Identification Number
13. Height and Weight — Member Height _____ inches Weight _____ lbs	14. Date of Birth — Member
15. Place of Service (choose one) ❑ 11 = Office ❑ 12 = Home ❑ 31 = Skilled Nursing Facility ❑ 32 = Nursing Facility ❑ 99 = Other Place of Service	16. Name and Address — Facility (if applicable)

SECTION III — CLINICAL INFORMATION

17. Estimated Length of Need (1-98 months; 99 = Lifetime) _____ months	18. Diagnosis — Codes and Descriptions Primary — Secondary —

19. Qualifying Test — Enter results of test taken within 60 days prior to the date of submission or requested start date of the PA request. Test results are to be available in the member's record or case file. **Note: Criteria for coverage of oxygen-related services include either an oxygen saturation level (SAO_2) of 88 percent or lower or an arterial blood gas level (PO_2) of 55 mm/Hg or lower at rest.**

a) Date b) Member condition during test (choose one) ❑ At rest ❑ During exercise ❑ During sleep c) Arterial blood gas level (PO_2) _____ mm/Hg d) Oxygen saturation level (SAO_2) _____%	e) Name, Address, and Credentials — Provider Performing Qualifying Test

Continued

SECTION III — CLINICAL INFORMATION (cont.)

20. Enter the oxygen liter flow rate / number of hours per day as prescribed by the physician.

a) _____ Liters per minute

b) _____ Hours per day

c) _____ Days per week

d) _____ Continuous

e) _____ PRN, describe circumstances and frequency of use —

21. Type of Oxygen Prescribed	22. Means of Delivery Prescribed
❑ Concentrator	❑ Nasal Cannula
❑ Liquid	❑ Mask
❑ Gaseous	❑ Other (Specify) _____

23. Indicate portable oxygen and member mobility information, if applicable.

a) Is portable oxygen prescribed?	❑ Yes	❑ No	❑ N/A
b) If portable oxygen is prescribed, is the member mobile?	❑ Yes	❑ No	❑ N/A

c) If the member is mobile and portable oxygen is prescribed, describe to what extent the member is mobile.

24. If the member's arterial blood gas level (PO_2) is 56 mm/Hg or above or the member's oxygen saturation level (SAO_2) is 89 percent or above at rest, answer questions a-d.

a) Does member have clinical evidence of chronic or recurrent congestive heart failure?	❑ Yes	❑ No	❑ N/A
b) Does member have cor pulmonale or pulmonary hypertension documented by P pulmonale on an electrocardiogram or by an echocardiogram, gated blood pool scan, or direct pulmonary artery pressure measurement?	❑ Yes	❑ No	❑ N/A
c) Does member have clinical evidence of decubital angina?	❑ Yes	❑ No	❑ N/A
d) Does member have erythrocythemia with a hematocrit greater than 56 percent?	❑ Yes	❑ No	❑ N/A

25. Describe the medical condition of the member that supports the use of oxygen (e.g., describe why the member needs this equipment).

SECTION IV — PHYSICIAN PRESCRIPTION

26. Date of Prescription (MM/DD/CCYY)

27. Prescription as Written

If the prescribing physician signs the PA/OA, ForwardHealth will accept it in lieu of the physician's written prescription, and there is no need to attach a photocopy of the prescription to the PA/OA. The prescription or this attachment must be signed and dated by the physician within 30 days prior to the date of receipt by ForwardHealth or the requested start date of the PA request.

28. **SIGNATURE** — Prescribing Physician	29. Date Signed

Reset Form