

**FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)
COMPLETION INSTRUCTIONS
FOR RESIDENTIAL CARE CENTER TREATMENT SERVICES**

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 (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stats. § 49.45(4), 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. The use of the Prior Authorization Request Form, F-11018, is mandatory when requesting PA for certain services. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with all applicable service-specific attachments, including the Prior Authorization/Residential Care Center Treatment Services Attachment (PA/RCCA) for Initial Admission and Unplanned Readmission Within 90 Days of Discharge from RCC, F-11076A, or the Prior Authorization Residential Care Center Treatment Services Attachment (PA/RCCA) for Continuing Services, F-11076B, to ForwardHealth by fax 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 — PROVIDER INFORMATION

Element 1 — HealthCheck “Other Services” and Wisconsin Chronic Disease Program (WCDP)

Enter an “X” in the box next to HealthCheck “Other Services” if the services requested on the PA/RF are for HealthCheck “Other Services.” Enter an “X” in the box next to Wisconsin Chronic Disease Program (WCDP) if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type

Enter 126 — Psychotherapy (CMS 1500 billing providers only). The process type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no process type is indicated.

Element 3 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the residential care center.

Element 4 — Name and Address — Provider

Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a of the PA/RF.

Element 5a — Billing Provider Number

Enter the provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider number of the billing provider in Element 5a.

Element 6a — Name — Prescribing/Referring/Ordering Provider

Enter the prescribing/referring/ordering provider's name.

Element 6b — National Provider Identifier — Prescribing/Referring/Ordering Provider

Enter the prescribing/referring/ordering provider's 10-digit National Provider Identifier (NPI).

SECTION II — MEMBER INFORMATION

Element 7 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or the Electronic Verification System (EVS) to obtain the correct member ID.

Element 8 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format (e.g., September 8, 1966, would be 09/08/1966).

Element 9 — Address — Member

Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. Include the name of the residential care center.

Element 10 — Name — Member

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

Element 11 — Gender — Member

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 12 — Diagnosis — Primary Code and Description

Enter the appropriate and most-specific *International Classification of Diseases* (ICD) diagnosis code and description most relevant to the service requested. The ICD diagnosis code must correspond with the ICD description.

Element 13 — Start Date — SOI (not required)

Element 14 — First Date of Treatment — SOI (not required)

Element 15 — Diagnosis — Secondary Code and Description

Enter the appropriate and most-specific secondary ICD diagnosis code and description most relevant to the service requested, if applicable.

Element 16 — Requested PA Start Date

Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested.

Element 17 — Rendering Provider Number (not required)

Enter the NPI of the provider who will be performing the service only if the NPI is different from the NPI of the billing provider listed in Element 5a.

Element 18 — Rendering Provider Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider who will be performing the service, only if this code is different from the taxonomy code listed for the billing provider in Element 5b.

Element 19 — Service Code

Enter Healthcare Common Procedure Coding System procedure code H0019.

Element 20 — Modifiers

Enter the appropriate modifier:

- | | |
|-------------------------------|------------------------|
| U1 — Standard Residential | U5 — Medically Complex |
| U2 — Assessment | U6 — Sex Offender |
| U3 — Behavioral Stabilization | U7 — Boys |
| U4 — Intensive Needs | U8 — Girls |

Element 21 — POS

Enter place of service code 99.

Element 22 — Description of Service

Enter behavioral health; long term residential.

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Element 23 — QR

Enter the number of days of service being requested.

For initial admissions to the RCC, the maximum number of days that can be requested and authorized is 365 (366 in leap years).

For unplanned readmissions within 90 days of discharge from the RCC, the number of days requested should be determined by the medical necessity of the services as stated in the member's treatment plan.

For children who are served in the RCC for intermittent services, the number of days requested should be calculated as the number of days the child is served in the RCC as determined by the medical necessity of the services as stated in the member's treatment plan.

Element 24 — Charge

Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the Department of Health Services.

Element 25 — Total Charges

Enter the anticipated total charge for this request.

Element 26 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 27 — Date Signed

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