STATE OF WISCONSIN

HFS 106.03(4), Wis. Admin. Code HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. Instructions: Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I —	PROVIDER INF	ORMATIO	N	-	<u>:</u>	-				- V			
						Process Type				3. Telephone Number — Billing Provider			
☐ HealthCheck "Other Services"													
☐ Wisconsin	Chronic Disease	Program (W	CDP)	1					- 1				
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)									5a. Billing Provider Number				
*									5b. Billing Provider Taxonomy Co			ode	
SECTION II -	- MEMBER INF	ORMATIO	1										
6. Member Identification Number 7. Date of Birth -					- Member 8.				8. <i>A</i>	3. Address — Member (Street, City, State, ZIP Code)			
Name Mer	mber (Last First N	/liddle Initial)		-т	10 G	ender	Mem	ber					
or realise menus.					☐ Male ☐ Female					*			
SECTION III -	- DIAGNOSIS /	TREATME	NT INFO	RMA	TION								
11. Diagnosis — Primary Code and Description 12. Start Date — SOI 13. First										st Date of Treatment — SOI			
14. Diagnosis –	- Secondary Code	and Descrip	otion				15. Re	questec	A PA	Start Date			
6. Rendering 17. Rendering 18. Service 19. Modifiers							20. 21. De			escription of Service		22. QR	23. Charge
Provider Number	Provider Taxonomy Code	Code	1	2			POS						
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s provided and the	completeness of the	claim information	n. Payment	Mill not	be mad	e for se	tology and	nolicy If	the n	ber and provider at the time the pproval or after the authorization number is enrolled in a Badge newed only if the service is not	Care Plus	24. Total Charges	\$0.00
Managed Care Pro the Managed Care	gram at the time a pri-	or authorized se	ervice is provi	ded, Fo	orwardi	ieaith r	eimbursen	ISTIL WILL D	re alic	owed only if the service is not o	~ Tuish uj	26. Date \$	Signed
25. SIGNATUR	RE — Requesting	Provider										Zo. Date 3	ngrieu