

FORWARDHEALTH PRIOR AUTHORIZATION / BIRTH TO 3 ATTACHMENT (PA/B3)

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. Stat. § 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. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain services. Refer to the applicable service-specific publications for service restrictions and documentation requirements.

REMINDER TO PROVIDERS

Providers are reminded that all services must meet the rules and regulations of ForwardHealth as found in Wis. Admin. Code chs. DHS 101-108. Providers are further reminded that prior authorization (PA) does not guarantee payment for the service.

SUBMITTING PRIOR AUTHORIZATION REQUESTS

Attach this form to the Prior Authorization Request Form (PA/RF), F-11018. Providers may submit PA requests 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

Providers should make duplicate copies of all paper documents mailed to ForwardHealth.

Name — Member (Last, First, Middle Initial)	Member Identification Number
Name — Therapist (Last, First, Middle Initial)	Therapist's or Rehabilitation Agency's National Provider Identifier

By my signature below, I hereby attest that:

- I am providing an evaluation completed for the purpose of determining the member's eligibility for the Birth to 3 (B-3) Program or for the purpose of initiating and/or providing therapy services as part of the Individualized Family Service Plan (IFSP) developed for the member.
- OR**
- I am providing ongoing therapy services, and I certify that all of the following are true:
 - The IFSP for the child named above was or will be developed and implemented in accordance with the requirements set forth in DHS 90, Wis. Admin. Code.
 - The therapy services I am providing to the member named above are as stated in the child's current and valid IFSP.
 - The frequency and duration of services I am providing to the child named above reflects the frequency and duration of services listed in the member's IFSP.
 - The member of the services is enrolled in a B-3 Program for all dates of service and is younger than three years of age.
 - I am a therapist employed by a B-3 Program or am under agreement with a B-3 agency to provide B-3 services.
 - The therapy services provided meet all the applicable rules and regulations as stated in Wis. Admin. Code chs. DHS 101-108 and ForwardHealth publications.
 - I understand that I am required to maintain a record of services provided to the child named above, per Wis. Admin. Code ch. DHS 106.

SIGNATURE — Therapist	Date Signed (MM/DD/CCYY)
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