

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / CHIROPRACTIC ATTACHMENT (PA/CA) 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 mandatory when requesting PA for certain services. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the case.

Attach the completed Prior Authorization/Chiropractic Attachment (PA/CA), F-11029, to the Prior Authorization Request Form (PA/RF), F-11018, and physician prescription (if necessary) and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. 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

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s). Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.

**SECTION I — PROVIDER INFORMATION**

**Element 1 — Name — Provider**

Enter the name of the provider who would perform/provide the requested service/procedure.

**Element 2 — Address — Clinic or Office Where Service(s) Is Provided**

Enter the address of the clinic or office where chiropractic services are actually performed.

**Element 3 — National Provider Identifier**

Enter the National Provider Identifier of the chiropractor performing the service.

**Element 4 — Telephone Number — Provider**

Enter the telephone number, including area code, of the provider performing the service.

**SECTION II — MEMBER INFORMATION**

**Element 5 — Name — Member**

Enter the member's last name, 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 spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 6 — Date of Birth — Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 7 — Member Identification Number**

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

### SECTION III — SERVICE INFORMATION

**Element 8 — Total Number of Services Requested (Specify)**

Enter the total number of visits/services requested.

**Element 9 — Total Number of Weeks Requested**

Enter the total number of weeks to complete requested visits.

**Element 10 — Requested Start Date of Prior Authorization**

Enter the date to begin services in MM/DD/CCYY format.

### SECTION IV — SUPPORTING INFORMATION

**Element 11 — Date of Spell of Illness**

Enter the date the spell of illness (SOI) began in MM/DD/CCYY format.

**Element 12 — Date of Beginning Treatment**

Enter the first date of treatment for this SOI in MM/DD/CCYY format.

**Element 13 — History**

- a. Initial — Explain history of initial treatment for member. (Leave blank if this SOI is initial treatment.)
- b. Spell of Illness — Explain history for this SOI.
- c. Previous and/or Concurrent Care — List previous or concurrent care relating to this SOI, if known.

**Element 14 — Subjective Complaints**

- a. Initial — Explain initial complaints. (Leave blank if this SOI is initial treatment.)
- b. Spell of Illness — Explain complaints relating to this SOI.

**Element 15 — Objective Findings**

- a. Initial — Explain objective findings of initial treatment. (Leave blank if this SOI is initial treatment.)
- b. Spell of Illness — Explain objective findings relating to this SOI.
- c. Diagnosis — Enter the appropriate BadgerCare Plus-allowable diagnosis code.

**Element 16 — Subjective Progress**

Enter the subjective progress of the member. Are the frequency, intensity, distribution, and duration less? What has improved subjectively?

**Element 17 — Objective Progress**

Enter the objective progress of the member. What former positive tests are now negative or less positive?

**Element 18 — Prognosis / Treatment Plan**

Enter the prognosis and treatment plan for the member.

**Element 19 — Additional Comments**

Enter any additional comments that may assist the ForwardHealth medical consultants' decision in adjudicating the PA request. Examples include lifestyle choices, general health, or extenuating circumstances which slow the member's progress.

**Elements 20 and 21 — SIGNATURE — Examining / Treating Provider and Date Signed**

The examining or treating provider must sign this element. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/CCYY format.

*Note:* The signature may be a computer-printed or typed name and date or a signature stamp with the date.