FORWARDHEALTH

PRIOR AUTHORIZATION / SPELL OF ILLNESS ATTACHMENT (PA/SOIA) 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 (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. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of the Prior Authorization/Spell of Illness Attachment (PA/SOIA), F-11039, is mandatory when requesting SOI. 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 request.

Attach the completed PA/SOIA to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers may submit PA requests on the ForwardHealth Portal at *www.forwardhealth.wi.gov/*, 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. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

An SOI ends when the maximum allowable treatment days have been used or when the physical therapy (PT), occupational therapy (OT), or speech and language pathology (SLP) services are no longer required, whichever comes first.

SECTION I — MEMBER INFORMATION

Element 1 — 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 2 — Age — Member
Enter the age of the member in numerical form (e.g., 16, 21, 60).

Element 3 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Therapist
Enter the name and credentials of the primary therapist participating in therapy services for the member. If the rendering provider is a therapy assistant, enter the name of the supervising therapist.

Element 5 — National Provider Identifier (NPI) — Therapist
Enter the rendering provider's National Provider Identifier (NPI). If the rendering provider is a therapy assistant, enter the NPI of the supervising therapist. Rehabilitation agencies do not indicate a rendering provider.

Element 6 — Telephone Number — Therapist
Enter the rendering provider's telephone number, including the area code, of the office, facility, or place of business. If the rendering provider is a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Prescribing Physician
Enter the name of the prescribing physician.

Element 8 — NPI — Prescribing Physician
Enter the NPI of the prescribing physician.

SECTION III — DOCUMENTATION

Element 9
Enter an "X" in the appropriate box to indicate a PT, OT, or SLP SOI request.

Element 10 — Requested Start Date
Enter the requested start date for service(s) in MM/DD/CCYY format.

Element 11 — Primary *International Classification of Diseases* (ICD) Diagnosis Code or ICD Procedure Code and Description
Enter the appropriate and most-specific primary *International Classification of Diseases* (ICD) diagnosis code or ICD procedure code and its corresponding description.

Element 12
Check the appropriate box to indicate which statement describes the type of therapy the member requires. Only one of the five statements should be selected.

Element 13
Check the appropriate box to indicate whether or not the member displays the potential to re-achieve the skill level he or she had previously.

Element 14 — Signature — Therapist Providing Evaluation / Treatment
The signature of the therapist providing evaluation/treatment must appear in the space provided.

Element 15 — Date Signed
Enter the month, day, and year the PA/SOIA was signed in MM/DD/CCYY format.