FORWARDHEALTH
PERSONAL CARE ADDENDUM 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 services.

The Personal Care Addendum, F-11136, may be completed to supply additional information when requesting PA or for members requesting an amendment to a PA request. The use of this form is mandatory when supplying additional information when requesting PA or for members requesting an amendment to a PA request. 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 request.

Retain the original, signed Personal Care Addendum. Attach a copy of the Personal Care Addendum to a copy of the plan of care, any additional supporting materials that justify or explain the requested changes, and other documents as directed by ForwardHealth personal care (PC) policy. Providers may submit PA documents 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

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).

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Provider
Enter the name of the ForwardHealth-certified PC agency providing services to the member.

Element 2 — Provider Number
ForwardHealth providers are required to enter a National Provider Identifier (NPI). Non-healthcare providers are required to enter their Provider ID.

SECTION II — MEMBER INFORMATION

Element 3 — 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 4 — 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 III — GENERAL ASSESSMENT

Element 5 — Skilled Visits Required by Member
Enter an "X" next to all visits required by the member.

If the member is eligible for Medicare, cannot reasonably obtain services outside the residence, and requires a skilled service, Medicare must be maximized before claims may be submitted to ForwardHealth, including disposable medical supplies and durable medical equipment. However, providers should request PA for all ForwardHealth-covered services, including those billed to other payers.

Element 6 — Communication Capability
Enter an "X" next to the statement that most closely matches the manner in which the member makes his or her needs known.

Element 7 — Hearing Aid Usage
Enter an "X" to indicate whether or not the member wears a hearing aid.

If the member wears a hearing aid, enter an "X" next to the statement that most closely matches his or her ability to hear while using the hearing aid.

Element 8 — Vision Correction
Enter an "X" to indicate whether or not the member wears corrective lenses.

If the member wears corrective lenses, enter an "X" next to the statement that most closely matches his or her ability to see while using the corrective lenses.

Element 9 — Orientation
Enter an "X" next to the statement that most closely describes the member's orientation awareness to the present environment in relation to time, place, and person.

Element 10 — Medications
Enter all medications prescribed for the member. Include the dosage, frequency, route, and start and stop dates for each medication listed.

This information is required regardless of which provider or agency administers or assists with administration of the medications.

Element 11 — Supporting Rationale for Requested Increase of Units
Document the specifics and supporting rationale for the increase in requested units. Attach additional pages if necessary.

SECTION IV — SOCIAL INFORMATION

Element 12 — Social / Economic / Cultural Factors
Identify and explain any social, economic, and/or cultural factors of the member that may impact the need for PC services or how the services are provided.

Element 13 — Scheduled Activities Outside Residence
Enter an "X" to indicate if the member attends regularly scheduled activities outside his or her place of residence.

If the member attends regularly scheduled activities outside his or her residence, provide the weekly schedule for these activities. Specify the times of day each activity takes place (e.g., 8 a.m.-3 p.m., school).

SECTION V — HISTORY OF CONDITION

Element 14 — Condition / Past and Present Problems Affecting Personal Care
Enter the member's condition and any past or present problems that directly affect the provision of PC services.

SECTION VI — STAFFING SCHEDULE

Element 15 — Staffing Schedule of Each Agency or Provider Providing Services
Enter the scheduled times that each agency or provider provides services to the member and indicate the funding source. Staffing may vary on a day-to-day basis at the convenience of the member. Agencies/providers may not vary schedule times without the approval of the member. Specify the times of day each provider provides services. If the schedule varies, enter the schedule that most closely resembles the services usually provided (e.g., PCW 8am-10am, HHAide 10am-2pm, PCW 6pm-8pm).

Element 16 — Other Information
Document any other information that supports the need for PC services and the justification for the time that is required to provide the services. Attach additional pages if necessary.

SECTION VII — SIGNATURE

Element 17 — SIGNATURE — Authorized Nurse Completing Form
The registered nurse (RN) completing this Personal Care Addendum is required to sign this form.

Element 18 — Date Signed
Enter the date that the RN completing this Personal Care Addendum signed the form.