FORWARDHEALTH

PRIOR AUTHORIZATION / SPEECH-GENERATING DEVICE SKILLS AND NEEDS PROFILE ATTACHMENT INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

ForwardHealth members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. Per Wis. Admin. Code § DHS 104.02(4), this information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number.

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is only 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.

INSTRUCTIONS: Under Wis. Admin. Code § DHS 106.02(9)(e), the provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of PA requests. The provider is responsible for submitting sufficient information to support the medical necessity of the requested equipment or supplies. If the space provided is not sufficient, attach additional pages for the provider's responses and/or an occupational or physical therapy report if available. All speech-generating devices (SGDs) must be prescribed by a physician. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements.

The speech-language pathologist is required to complete the Prior Authorization/Speech-Generating Device Skills and Needs Profile Attachment form and the Prior Authorization/Speech-Generating Device Purchase Recommendation Attachment form, F-02493, or to submit a speech and language pathology (SLP) report documenting the same content as the two attachments. The speech-language pathologist is required to submit the completed forms or documentation to the SGD vendor with any additional required documentation attachments. The SGD vendor may submit the forms and any required documentation 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).

SECTION I – MEMBER INFORMATION

Element 1: Name – Member
Enter the member's last name, followed by their 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 the spelling of the name on the ForwardHealth ID card and the EVS do not match, use the spelling from the EVS.

Element 2: Member ID Number
Enter the member ID. Do not enter any other numbers or letters.

Element 3: Date of Birth – Member
Enter the member's date of birth in mm/dd/ccyy format.

SECTION II – SERVICE INFORMATION

Element 4: Medical Diagnosis
Enter the member's medical diagnosis.

Element 5: Treatment Diagnosis
Enter the member's treatment diagnosis.

Element 6: Member's/Family's Native Language
Enter the member's or the member's family's native language.

Element 7
Check the appropriate box to indicate whether or not the member is a dual language learner. If yes, specify the languages.

Element 8: Date(s) or Range of Dates Needed for Completion of the Skills and Needs Profile
Enter the date(s) or range of dates that were needed to complete the skills and needs profile.

SECTION III – BACKGROUND INFORMATION

Element 9
Enter who referred the member for evaluation and why.

Element 10
Briefly describe the member's living situation.

Element 11
List the member's relevant medical history.

Element 12
Check the appropriate box to indicate whether or not the member has previously received SLP services focusing on alternative and augmentative communication (AAC). If yes, describe the timeframe and location of previous treatment and the reason that the current SGD skills and needs profile is needed.

Element 13
Include additional background information or history if applicable. For instance, discuss any other pertinent SLP services the member has received in the past or is currently receiving, and discuss how the provider will coordinate services with other providers. Attach the Individualized Family Service Plan (IFSP) for Birth to 3 Program-aged members if applicable. Attach the Individualized Education Program (IEP) for school-aged members (3–21 years old) if applicable.

SECTION IV – CONFIRMING NEED FOR SGD EVALUATION

Element 14
Check all the boxes that apply to the member. Include additional information confirming the member's need for an SGD evaluation if applicable.

SECTION V – EVALUATION OF SKILLS RELEVANT TO COMMUNICATING USING AN SGD

Element 15
Check all the boxes that describe the member's speech skills. Include additional information regarding speech skills if applicable.

Element 16
Check all the boxes that describe the member's receptive language skills. Include additional information regarding receptive language skills if applicable.

Element 17
Check all the boxes that describe the member's expressive language skills. Briefly describe the member's vocabulary status and grammatical skills/language complexity. Include additional information regarding expressive language skills if applicable.

Element 18
Check all the boxes that describe the member's communication skills. Include additional information regarding communication skills if applicable.

Element 19
Check all the boxes that describe the member's cognitive skills. Include additional information regarding cognitive skills if applicable.

Element 20
Check all the boxes that describe the member's learning style and context requirements related to SGD use. Include additional information regarding learning style and context requirements if applicable.

Element 21
Check the box that describes the member's hearing skills. Include additional information regarding the member's hearing status if applicable.

Element 22
Check **one** of the boxes to describe the member's vision skills. Include additional information regarding the member's vision skills if applicable.

Element 23
Check **one** of the boxes to describe the member's fine motor skills. Attach a report from an occupational therapist or physical therapist if applicable. Include additional information regarding fine motor status if applicable.

Element 24
Check all the boxes that describe the member's gross motor skills/mobility/positioning. Attach a report from the occupational therapist or physical therapist if applicable.

SECTION VI – RECOMMENDATIONS

Element 25
Include recommendations following the completion of the skills and needs profile in the space provided. Recommendations should include whether or not the member will need additional treatment and/or a trial period using the SGD.

SECTION VII – AUTHORIZED SIGNATURE

Element 26: SIGNATURE AND CREDENTIALS – Speech-Language Pathologist
Enter the signature and credentials of the speech-language pathologist.

Element 27: Date Signed
Enter the month, day, and year the form was signed (in mm/dd/ccyy format).