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Description automatically generated**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 75.51

F-03325 (02/2025)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / INTENSIVE OUTPATIENT PROGRAM ATTACHMENT (PA/IOP)**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, refer to the Prior Authorization/Intensive Outpatient Program Attachment (PA/IOP) Instructions, F-03325A. Providers may refer to the Forms page of the ForwardHealth Portal at [www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ ForwardHealthCommunications.aspx?panel=Forms](file:///\\usmds011.prod.healthcare.wi.local\Control\Provider%20Relations\PUBS\Forms\2024%20DRAFTS\PA\FXXXXX%20PA%20Intensive%20Outpatient_NEW\www.forwardhealth.wi.gov\WIPortal\Subsystem\Publications\%20ForwardHealthCommunications.aspx%3fpanel=Forms) for the completion instructions.

The IOP provider must complete, sign, and date the form. The IOP provider may submit PA requests to ForwardHealth via the ForwardHealth Portal, by fax at 608‑221-8616, or by mail to ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784.

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| **SECTION I – MEMBER INFORMATION** | | | |
| 1. Name – Member (Last, First, Middle Initial) | | | |
| 2. Date of Birth – Member | 3. Member ID Number | | |
| **SECTION II – SERVICE REQUEST** | | | |
| 4. Select **one** type of service:  Substance Use Disorder (SUD) Only  Co-Occurring SUD and Mental Health  Mental Health Only | | 5. Indicate any additional complexities that are present. Check all that apply.  Intellectual / Development Disability  Justice Involved  Pregnant / Postpartum  Under Age 18 | |
| **SECTION III – ASSESSMENT FOR SUBSTANCE USE TREATMENT** | | | |
| Complete this section for SUD Only or Co-Occurring SUD and Mental Health service requests. This section is optional for Mental Health Only. | | | |
| 6. Date – Most Recent American Society of Addiction Medicine (ASAM) Assessment | | | |
| 7. Name – Clinical Assessor | | | |
| 8. Division of Safety and Professional Services (DSPS) Credentials – Clinical Assessor | | | |
| 9. Name – Clinical Supervisor (Required only if the clinical assessor is in training.) | | | |
| 10. DSPS Credentials – Clinical Supervisor (Required only if the clinical assessor is in training.) | | | |
| 11. Diagnosed Substance Use Conditions (Enter up to three diagnoses and codes.)  Primary Diagnosis       Code:  Secondary Diagnosis       Code:  Tertiary Diagnosis       Code: | | | |
| 12. Determined ASAM Level of Care (Select **one** of the following.)  Outpatient Services  Intensive Outpatient Services  Partial Hospitalization Services  Low-Intensity Residential  High-Intensity Residential  Medically Monitored Intensive Inpatient  Medically Managed Intensive Outpatient | | | |
| 13. Has the substance use treatment plan been completed?  Yes  No | | | |
| 14. Member’s Medication-Assisted Treatment (MAT) Status (Select **one** of the following.)  Member is continuing an existing course of MAT.  Member will begin a course of MAT while receiving IOP.  Member has been informed of MAT and is refusing MAT at this time. Date of Refusal:  Note: Refusal must be documented in the member’s record.  MAT is not recommended for this diagnosis. Provide diagnosis code:  MAT is not offered or made available at this facility.  Other MAT status: | | | |
| **SECTION IV – ASSESSMENT FOR MENTAL HEALTH TREATMENT** | | | |
| Complete this section for Mental Health Only or Co-Occurring SUD and Mental Health service requests. This section is optional for SUD Only. | | | |
| 15. Date – Most Recent Mental Health Assessment | | | |
| 16. Name – Clinical Assessor | | | |
| 17. DSPS Credentials – Clinical Assessor | | | |
| 18. Name – Supervisor (Required only if the clinical assessor is in training.) | | | |
| 19. DSPS Credentials – Supervisor (Required only if the clinical assessor is in training.) | | | |
| 20. Diagnosed Mental Health Conditions (Enter up to three diagnoses and codes.)  Primary Diagnosis       Code:  Secondary Diagnosis       Code:  Tertiary Diagnosis       Code: | | | |
| 21. Assessment Tool Used (Select **one** of the following if a standardized assessment was used.)  Level of Care Utilization System (LOCUS) Score:  Child and Adolescent Level of Care Utilization System (CALOCUS) Score:  LOCUS-Child and Adolescent Service Intensity Instrument (CASII) Score:  LOCUS-Early Childhood Service Intensity Instrument (ECSII) Score:  Other:       Score: | | | |
| 22. Has the mental health treatment plan been completed?  Yes  No | | | |
| 23. Level of Care Indicated by the Assessment | | | |
| **SECTION V – TREATMENT CURRICULUM** | | | |
| Complete this section for all service requests. | | | |
| 24. Indicate the planned treatment curriculum or program for the member.  The Matrix Model  Dialectical Behavior Therapy (DBT)  Cognitive Behavioral Therapy (CBT)  Cognitive Behavioral Therapy – Enhanced (CBT-E)  Acceptance Commitment Therapy (ACT)  Other:  No specific curriculum or program | | | |
| **SECTION VI – SIGNATURE** | | | |
| I attest to the accuracy of the information on this PA request. I further attest that the individuals completing the assessments referenced above have the professional training and certification(s) to assess the member’s current mental health and/or SUD treatment needs and identify the most appropriate, least restrictive level of care needed at this time. | | | |
| 25. **SIGNATURE** | | | 26. Date Signed |