DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-03325 (02/2025)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 75.51

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 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.

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: _____

DT-PA135-135

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

Reset Form