DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-03327 (11/2024)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.02(3)

FORWARDHEALTH

PRIOR AUTHORIZATION / PEDIATRIC HOSPITAL BED (PA/PHB)

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Pediatric Hospital Bed (PA/PHB) Instructions, F-03327A. 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.

Providers must complete, sign, and date the form. The 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. Member ID Number	3. Date of Birth – Member

SECTION II – PROVIDER INFORMATION

4. Name – Prescribing Provider

5. National Provider Identifier – Prescribing Provider

6. Phone Number – Prescribing Provider	7. Phone Number – Dispensing Provider

SECTION III – SERVICE INFORMATION

8. Check the box that most accurately indicates what kind of assistance the member needs for mobility and self-care.

Ambulation: ❑ Independent ❑ Supervision ❑ Assist of 1 ❑ Assist of 2 or Dependent

Transfers: ❑ Independent ❑ Supervision ❑ Assist of 1 ❑ Assist of 2 or Dependent

Activities of Daily Living (ADL):

❑ Independent ❑ Supervision ❑ Assist of 1 ❑ Assist of 2 or Dependent

Describe which ADLs require assistance. Include in the description if assistance varies widely or if it is only required for certain ADLs.

❑ Other (specify) ___

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9. Check the box to indicate the member's level of strength and coordination.
   - ❑ Within Normal Limits (WNL)
   - ❑ Within Functional Limits (WFL)
   - ❑ Impaired
     If impaired, explain:

10. Check the box to indicate the member's cognitive and communication status as it relates to age-appropriate skills.
    Cognitive Status
    - ❑ WNL
    - ❑ WFL
    - ❑ Impaired
      If impaired, explain:

    Communication Status
    - ❑ WNL
    - ❑ WFL
    - ❑ Impaired
      If impaired, explain:

Describe the member's home environment.

11. Check the box to indicate the member's type of home.
    - ❑ Single-Story House
    - ❑ Multi-Story House
    - ❑ Apartment

12. Does the member use other durable medical equipment in the home? ❑ Yes ❑ No
    If yes, describe what equipment the member uses.

13. Does the member have help from a home health worker, personal care worker, or registered nurse? ❑ Yes ❑ No
    If yes, how many hours per day? ____________

14. Is the member in school or day care? ❑ Yes ❑ No
    If yes, how many hours per day? ____________

15. Does the member spend time alone at home? ❑ Yes ❑ No
    If yes, how many hours per day? ____________

16. Describe any current environmental or sensory modifications. Modifications include the use of any safety devices used to confine or monitor the member, or any sensory modifications made to the member's environment or home to address member preferences or needs.

Compare alternative options to the requested hospital bed.

17. Describe why the member is not able to use either a standard bed or crib with bumper pads, padded rails, or head-of-bed horseshoe padding.

18. Describe why the member is not able to use a standard hospital bed with or without padding, including a hi-low hospital bed with or without rails.

19. Describe the member's positioning needs. Include how long pillows and wedges were trialed and why they were insufficient for the member's needs.

20. Describe how often the member needs to be repositioned and how quickly the member would need to be repositioned.

21. If the PA request is for a semi-electric bed, can the member operate the bed controls independently?

    ❑ Yes ❑ No

22. If the PA request is for a total electric bed, has the member tried multiple means of transfer, including setting the bed at an optimal height for transfers?

    ❑ Yes ❑ No

23. Describe medically necessary intervention the pediatric hospital bed provides for the member.

24. Does the member have a history of seizures? ❑ Yes ❑ No

    If yes, indicate the type, frequency, date of most recent seizure, and what interventions are required for management.

25. Describe the member's current sleeping situation.

List any prior injuries the member has experienced that resulted from their current sleeping situation.

26. Describe how any accessories are medically necessary (for example, padding or IV pole).

27. Describe the member's monitoring plan. In the attachments to this form, include a signed provider's order that the requested medical equipment is a restraint, and the member can receive the equipment to prevent harm to the member.

SECTION IV – REQUESTS FOR PEDIATRIC CRIBS OR FULL ENCLOSURE

Complete this section if the request is for either a pediatric crib or a full enclosure attachment. Pediatric hospital beds with rails that are 24 inches or higher will be considered cribs.

28. Explain what medical conditions will be addressed and how they will be managed with a full enclosure or pediatric crib.

29. Does the member demonstrate head-directed self-injury? ❑ Yes ❑ No

If yes, has the member experienced tissue damage? ❑ Yes ❑ No

Has the member used a protective helmet? ❑ Yes ❑ No

30. Explain how the member's behavior is different from other children of similar age who climb out of bed and wander.

31. Explain what current standard child safety devices are in place (for example, child locks or gates) and what commercial monitoring devices are in place (for example, baby camera).

32. Describe the comprehensive plan to eliminate or lessen the use of restrictive items, including measurable outcomes.

SECTION V – AUTHORIZED SIGNATURE

Attach a photocopy of the provider's prescription and face-to-face encounter to this form. Telehealth encounters are accepted but must include both audio and video. The prescription must be signed and dated within one year of receipt by ForwardHealth. The face-to-face visit must occur no more than six months before the signature date of the initial prescription.

I attest under penalty of law that the information provided above is truthful and accurate to the best of my knowledge. All responses are legally binding and will be used in the service authorization adjudication process.

33. **SIGNATURE** – Provider	34. Date Signed
35. Print Name – Provider	