**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.06(2)

F-03342 (01/2025)

**FORWARDHEALTH**

**IV KETAMINE INFUSION THERAPY ATTESTATION**

**INSTRUCTIONS:** Type or print clearly. The IV Ketamine Infusion Therapy Attestation form, F-03342, must be submitted with all prior authorization requests for IV ketamine infusion therapy. Providers may submit the completed, signed, and dated IV Ketamine Infusion Therapy Attestation form on the ForwardHealth Portal at [forwardhealth.wi.gov](https://www.forwardhealth.wi.gov/WIPortal/), by fax at 608‑221-8616, or by mail at:

ForwardHealth

Prior Authorization

Ste 88

313 Blettner Blvd

Madison WI 53784

Providers may call Provider Services at 800-947-9627 with questions.

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| **SECTION I – PROVIDER INFORMATION** | | |
| 1. Name – Provider | | |
| 2. Address – Provider (Street, City, Zip+4 Code) | | |
| 3. National Provider Identifier | 4. Phone Number – Provider | |
| **SECTION II – MEMBER INFORMATION** | | |
| 5. Name –Member (Last, First, Middle Initial) | | |
| 6. Member ID | 7. Date of Birth – Member | |
| **SECTION III – IV KETAMINE INFUSION THERAPY ATTESTATION** | | |
| 8. I attest that I have reviewed ForwardHealth’s policies and processes regarding IV ketamine infusion therapy. By checking the boxes below, I attest that each statement is true.  A treatment protocol is in place.  A monitoring protocol is in place.  Advanced cardiovascular life support (ACLS)-certified staff is on site at the time of the infusion.  I am a registered provider with the Drug Enforcement Agency (DEA). | | |
| 9. **SIGNATURE** – Provider | | 10. Date Signed |