DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-03342 (01/2025)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.06(2)

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, 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.

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

Reset Form