DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11035 (06/2024)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 106.03(4)
Wis. Admin. Code § DHS 152.06(3)(h)

FORWARDHEALTH

PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Dental Request Form (PA/DRF) Instructions, F-11035A. Providers may submit PA requests by fax to ForwardHealth at 608-221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784.

SECTION I – PROVIDER INFORMATION

1. Check only if applicable	2. Process Type (Check one)
❑ HealthCheck "Other Services"	❑ 124 (Dental)
❑ Wisconsin Chronic Disease Program	❑ 125 (Ortho)

3. Name and Address – Billing Provider (Street, City, State, Zip+4 Code)

4. Phone Number – Billing Provider	5a. Billing Provider Number
5b. Billing Provider Taxonomy Code	6a. Rendering Provider Number
6b. Rendering Provider Taxonomy Code	7. Requested Start Date

8. Name – Contact Person (Staff Member Filling Out This Form)	9. Phone Number – Contact Person

SECTION II – MEMBER INFORMATION

10. Member ID Number	12. Address – Member (Street, City, State, Zip+4 Code)
11. Date of Birth – Member	

13. Name – Member (Last, First, Middle Initial)	14. Gender – Member ❑ Male ❑ Female

SECTION III – DIAGNOSIS / TREATMENT INFORMATION

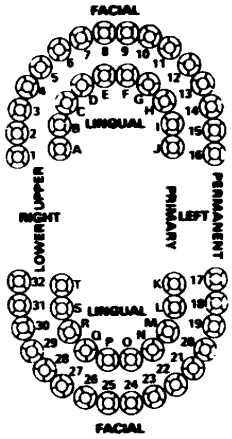
15. Place of Service (POS)

- ❑ Dental Office (POS Code 11)
- ❑ Outpatient Hospital (POS Code 22)
- ❑ Ambulatory Surgical Center (POS Code 24)
- ❑ Skilled Nursing Facility (POS Code 31)
- ❑ Other (Specify): _____

DT-PA016-016

16. Dental Diagram

- Check periodontal case type if applicable.
  - ❑ **I**
  - ❑ **II**
  - ❑ **III**
  - ❑ **IV**
  - ❑ **V**
- Cross out missing teeth.
- Circle teeth to be extracted.



Number of X-rays

_____

Type of X-rays

_____

Staple X-Ray Envelope Here

17. Area of Oral Cavity	18. Tooth	19. Procedure Code	20. Modifier	21. Description of Service	22. Quantity Requested	23. Charge
					24. Total Charges	

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus managed care program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the managed care program.

25. **SIGNATURE** – Rendering Provider	26. Date Signed
27. **SIGNATURE** – Member / Guardian (if applicable)	28. Date Signed

Reset Form