**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.13(3m), Wis. Admin. Code

F-11037 (07/2012)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA)**

Providers may submit prior authorization (PA) requests to ForwardHealth by fax at 608-221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA) Completion Instructions, F-11037A.

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| **SECTION I — MEMBER INFORMATION** |
| 1. Name — Member (Last, First, Middle Initial)      | 2. Age — Member      |
| 3. Member Identification Number      |
| **SECTION II — PROVIDER INFORMATION** |
| 4. Name and Credentials — Requesting / Rendering Provider      |
| 5. Telephone Number — Requesting / Rendering Provider      |
| **SECTION III — DOCUMENTATION** |
| 6. Describe length and intensity of treatment requested.* Program request is for       hours per day,

       days per week, for       weeks, for a total of       hours.* Anticipated beginning treatment date      .
* Estimated substance abuse day treatment discharge date      .
* Attach a copy of treatment design, which includes the following:
1. A schedule of treatment (day, time of day, length of session, and service to be provided during that time).
2. A brief description of aftercare / continuing care / follow-up component (also include this information in the treatment plan section of this form).
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| 7. List the dates of diagnostic evaluations or medical examinations and **specific** diagnostic procedures that were employed.      |

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| **SECTION III — DOCUMENTATION (Continued)** |
| 8. List the **current** primary and secondary diagnosis codes and descriptions from the most recent *Diagnostic and Statistical Manual of Mental Disorders* for the member’s current primary and secondary diagnosis.       |
| 9. Describe the member’s **current** clinical problems and relevant clinical history, including substance abuse history. (Give details of dates of abuse, substance[s] abused, amounts used, date of last use, etc.)       |
| 10. Has the member received any substance abuse treatment in the past 12 months? [ ]  Yes [ ]  NoIf “Yes,” provide information on the date of each treatment episode, the type of service provided, and the **treatment outcomes**.      |
| 11. Has the member received any inpatient substance abuse care, intensive outpatient substance abuse services, or substance abuse day treatment in the past 12 months? [ ]  Yes [ ]  NoIf “Yes,” give rationale for appropriateness and medical necessity of the current request. Describe projected outcome of additional treatment requested.       |

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| **SECTION III — DOCUMENTATION (Continued)** |
| 12. Describe the member’s severity of illness using the following indicators. Individualize all information.1. Loss of control / relapse crisis.
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| 1. Physical conditions or complications.
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| 1. Psychiatric conditions or complications. (Include psychiatric diagnosis, medications, current psychiatric symptoms.)
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| d. Recovery environment.       |
| e. Life areas impairment. (Specify social / occupational / legal / primary support group.)       |
| 1. Treatment acceptance / resistance.
 |
| 1. Treatment Plan
* **Attach** a copy of the member’s substance abuse day treatment plan (refer to intensity of service guideline in the substance abuse day treatment criteria).
* Describe any special needs of the member and indicate how these will be addressed (for example, educational needs, access to treatment facility).
* Describe the member’s family / personal support system. Indicate how these issues will be addressed in treatment, if applicable. If family members / personal support system are not involved in treatment, explain why not.
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| **SECTION III — DOCUMENTATION (Continued)** |
| 13. Treatment Plan (Continued)* Briefly describe treatment goals and objectives in specific and measurable terms.
* Describe the expected outcomes of treatment including the plan for continuing care.
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| I have read the attached request for PA of substance abuse day treatment services and agree that it will be sent to ForwardHealth for review. |
| **14. SIGNATURE** — Member or Representative      | 15. Date Signed      |
| 16. Relationship (If Representative)      |
| **17. SIGNATURE** — Rendering Provider       | 18. Date Signed      |
| 19. Discipline of Rendering Provider      |
| **20. SIGNATURE** — Supervising Physician or Psychologist       | 21. Date Signed      |
| 22. Supervising Physician or Psychologist’s NPI      |