DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11038 (07/2012)

STATE OF WISCONSIN
DHS 107.13(4), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION / ADULT MENTAL HEALTH DAY TREATMENT ATTACHMENT (PA/AMHDTA)

Providers may submit prior authorization (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. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA) Completion Instructions, F-11038A.

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. Requesting / Rendering Provider's National Provider Identifier (NPI)	6. Telephone Number — Requesting / Rendering Provider

SECTION III — DOCUMENTATION

7. Number of Hours per Week Requested	8. Estimated Final Treatment Date

9. Has the member had previous adult mental health day treatment at the provider's facility or elsewhere?

❑ Yes ❑ No ❑ Unknown

If "yes," list dates and locations.

10. Evaluation(s) (Include date[s], tests used, and results.)

Continued

DT-PA005-005

SECTION III — DOCUMENTATION (Continued)

11. Attach Section I of the member's most recent Functional Assessment. (The Mental Health Day Treatment Functional Assessment, F-11090, must be signed and dated within three months of receipt by ForwardHealth.)

12. Is the member's intellectual functioning below average? ❑ Yes ❑ No

    If "yes," what is the member's IQ score or intellectual functioning level, and how was this measured?

13. Provide a brief history pertinent to requested services. (Include psycho-social history, hospitalization history, family history, living situation history, etc.)

14. Describe progress / status since treatment began or was last authorized, if applicable.

Continued

SECTION III — DOCUMENTATION (Continued)

15. Specify overall character of service to be provided.

❑ Rehabilitation ❑ Maintenance ❑ Stabilization

16. Identify measurable treatment goals.

17. Attach a specific schedule of activities, including date, time of day, length of session, and service to be provided.

18. Estimate the member's rehabilitation potential for employment (competitive, supported, sheltered, etc.), social interaction, and independent living.

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SECTION III — DOCUMENTATION (Continued)

I have read the attached requests for PA of adult mental health day treatment services and agree that it will be sent to ForwardHealth for review.

19. SIGNATURE — Member or Representative	20. Date Signed
21. Relationship (If Representative)	
22. SIGNATURE — Therapist Providing Treatment	23. Date Signed
24. SIGNATURE — 51.42 Board Director / Designee (no longer required)	25. Date Signed (no longer required)