DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11020 (05/2013)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1)

Instructions: Type or print clearly. Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at 608-221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. Refer to the Prior Authorization Request for Hearing Instrument and Audiological Services (PA/HIAS1) Completion Instructions, F-11020A, for information on completing this form.

SECTION I — PROVIDER INFORMATION

1. Process Type	3. Name and Address — Testing Center (Street, City, State, ZIP+4 Code)
123	
2. Telephone Number — Testing Center	

4a. Testing Center Provider Number	4b. Testing Center Taxonomy Code
5a. Name — Prescribing Physician	5b. National Provider Identifier — Prescribing Physician

SECTION II — MEMBER INFORMATION

6. Name and Address — Member (Last, First, Middle Initial; Street, City, State, ZIP Code)	7. Member Identification Number	8. Gender — Member ❑ Male ❑ Female
	9. Date of Birth — Member	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Code and Description

11. Rendering Provider Number	12. Rendering Provider Taxonomy	13. Procedure Code	14. Modifiers 1	2	3	4	15. POS	16. Description of Service	17. QR	18. Charge

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 Medicaid and BadgerCare Plus 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, Medicaid reimbursement will be allowed only if the service is not covered by the Managed Care Program.

19. Total Charges

20. **SIGNATURE** — Requesting Provider	21. Provider Type ❑ Audiologist ❑ Hearing Instrument Specialist	22. Date Signed

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