FORWARDHEALTH

PRIOR AUTHORIZATION / CHIROPRACTIC ATTACHMENT (PA/CA)

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. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Chiropractic Attachment (PA/CA) Completion Instructions, F-11029A.

SECTION I — PROVIDER INFORMATION

1. Name — Provider

2. Address — Clinic or Office Where Service(s) Is Provided

3. National Provider Identifier	4. Telephone Number — Provider

SECTION II — MEMBER INFORMATION

5. Name — Member (Last, First, Middle Initial)	6. Date of Birth — Member

7. Member Identification Number

SECTION III — SERVICE INFORMATION

8. Total Number of Services Requested (Specify)	9. Total Number of Weeks Requested

10. Requested Start Date of Prior Authorization

SECTION IV — SUPPORTING INFORMATION

11. Date of Spell of Illness	12. Date of Beginning Treatment

13. History

a) Initial

b) Spell of Illness

c) Previous and / or Concurrent Care

Continued

SECTION IV — SUPPORTING INFORMATION (Continued)

14. Subjective Complaints
    a) Initial

    b) Spell of Illness

15. Objective Findings
    a) Initial

    b) Spell of Illness

    c) Diagnosis

16. Subjective Progress

17. Objective Progress

18. Prognosis / Treatment Plan

19. Additional Comments

20. **SIGNATURE** — Examining / Treating Provider	21. Date Signed

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