

## FORWARDHEALTH PRIOR AUTHORIZATION / PSYCHOTHERAPY ATTACHMENT (PA/PSYA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The Prior Authorization/Psychotherapy Attachment (PA/PSYA), F-11031, must be submitted with the request for outpatient mental health services. Use of the accompanying Outpatient Mental Health Assessment and Treatment/Recovery Plan form, F-11103, is optional when requesting PA for certain services.

Attach the completed PA/PSYA and the Outpatient Mental Health Assessment and Treatment/Recovery Plan form to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests electronically via the ForwardHealth Portal by accessing [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/), by fax to ForwardHealth at (608) 221-8616, or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
313 Blettner Blvd  
Madison WI 53784

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### GENERAL INSTRUCTIONS

The information contained in the PA/PSYA is used to make a decision about the amount and type of psychotherapy that is approved for ForwardHealth reimbursement. Thoroughly complete each section and include information that supports the medical necessity of the services being requested. Where noted in these instructions, material from personal records may be substituted for the information requested on the form. *Indicate on the PA/PSYA the intended use of the attached materials.*

Prior authorization for psychotherapy is not granted when another provider already has an approved PA for psychotherapy services for the same member. In these cases, ForwardHealth recommends that the member request that previous providers notify ForwardHealth that they have discontinued treatment with this member. The member may also submit a signed statement of his or her desire to change providers and include the date of the change. The new provider's PA may not overlap with the previous provider's PA.

### SECTION I — MEMBER INFORMATION

#### Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Date of Birth — Member

Enter the date of birth of the member (in MM/DD/CCYY format).

#### Element 3 — Member Identification Number

Enter the Member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

## SECTION II — PROVIDER INFORMATION

### Element 4 — Name and Address — Rendering Provider

Enter the name and address (street, city, state, ZIP+4 code) of the therapist who will be providing treatment.

### Element 5 — Rendering Provider National Provider Identifier

Enter the National Provider Identifier of the rendering provider.

### Element 6 — Telephone Number — Rendering Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the rendering provider.

### Element 7 — Discipline — Rendering Provider

Enter the discipline (credentials) of the therapist who will be providing treatment. The discipline should correspond with the name listed in Element 4.

## SECTION III — SERVICE REQUEST

Based on the information recorded on the Outpatient Mental Health Assessment and Treatment/Recovery Plan, the following services are requested.

### Element 8 — Number of Minutes Per Session

Indicate the length of session for each format listed.

### Element 9 — Frequency of Requested Sessions

Enter the anticipated frequency of requested sessions. If requesting sessions more frequently than once per week, describe why they are needed. If a series of treatments that are not regular is anticipated (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment requested, the time period over which the treatment is requested, and the expected pattern of treatment.

### Element 10 — Total Number of Sessions / Hours Requested for This PA Period

Indicate the total hours of treatment requested for this PA period, based on the information entered in Elements 21 and 22 of the PA/RF, and the duration of this request. (Services at intensities lower than an average of one hour weekly may be approved for up to six months' duration.) *This quantity should match the quantity(ies) in Element 22 of the PA/RF.*

### Element 11 — Treatment Approach

Indicate the type of treatment utilized. The treatment approach utilized must be consistent with the diagnosis and symptoms, and its effectiveness must be supported by clinical research.

### Element 12 — Estimated Termination Date

Indicate the estimated date for meeting long-term treatment goals.

### Element 13 — Signature — Rendering Provider

Enter the signature of the rendering provider.

### Element 14 — Date Signed

Enter the date the rendering provider signed the PA/PSYA (in MM/DD/CCYY format).