FORWARDHEALTH

PRIOR AUTHORIZATION / SUBSTANCE ABUSE ATTACHMENT (PA/SAA)

Providers may submit prior authorization (PA) requests and 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/Substance Abuse Attachment (PA/SAA) Completion Instructions, F-11032A.

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 — Rendering Provider

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

SECTION III — TYPE OF TREATMENT REQUESTED

7. Designate the type of treatment requested.

❑ Primary Intensive Outpatient Treatment

- ❑ Individual ❑ Group ❑ Family
- Number of minutes per session ____ Individual ____ Group ____ Family
- Sessions will be ❑ Twice / month ❑ Once / month ❑ Once / week ❑ Other (Specify) _____
- Requesting ____ hours per week, for ____ weeks
- Anticipating beginning treatment date _____
- Estimated intensive treatment termination date _____
- Attach a copy of treatment design, which includes the following:
  a) Schedule of treatment (day, time of day, length of session, and service to be provided during that time).
  b) Description of aftercare / follow-up component.

❑ Aftercare / Follow-Up Service

- ❑ Individual ❑ Group ❑ Family
- Number of minutes per session ____ Individual ____ Group ____ Family
- Sessions will be ❑ Twice / month ❑ Once / month ❑ Once / week ❑ Other (Specify) _____
- Requesting ____ hours per week, for ____ weeks
- Estimated discharge date from this component of care _____

Continued

SECTION III — TYPE OF TREATMENT REQUESTED (Continued)

7. Designate the type of treatment requested. (Continued)

❑ Affected Family Member / Codependency Treatment

- ❑ Individual ❑ Group ❑ Family
- Number of minutes per session ____ Individual ____ Group ____ Family
- Sessions will be ❑ Twice / month ❑ Once / month ❑ Once / week ❑ Other (Specify) _____
- Requesting ____ hours per week, for ____ weeks
- Anticipating beginning treatment date _____
- Estimated affected family member / codependency treatment termination date _____
- Attach a copy of treatment design, which includes the following:
  a) Schedule of treatment (day, time of day, length of session, and service to be provided during that time).
  b) Description of aftercare / follow-up component.

SECTION IV — DOCUMENTATION

8. Was the member in primary substance abuse treatment in the last 12 months? ❑ Yes ❑ No ❑ Unknown

If "yes," provide date(s), problem(s), outcome, and provider of service.

9. Enter the dates of diagnostic evaluation(s) or medical examination(s).

10. Specify diagnostic procedures employed.

Continued

SECTION IV — DOCUMENTATION (Continued)

11. Provide current primary and secondary diagnosis (refer to the current *Diagnostic and Statistical Manual of Mental Disorders*) codes and descriptions.

12. Describe the member's current clinical problems and relevant history. Include substance abuse history.

13. Describe the member's family situation. Include how family issues are being addressed and if family members are involved in treatment. If family members are not involved in treatment, specify why not.

14. Provide a detailed description of treatment objectives and goals.

Continued

SECTION IV — DOCUMENTATION (Continued)

15. Describe expected outcome of treatment (include use of self-help groups, if appropriate).

SECTION V — SIGNATURES

I have read the attached request for PA of substance abuse services and agree that it will be sent to ForwardHealth for review.

16. **SIGNATURE** — Member or Representative (Optional)	17. Date Signed
18. Relationship (If Representative)	
19. **SIGNATURE** — Rendering Provider	20. Date Signed
21. Discipline of Rendering Provider	22. Rendering Provider's NPI
23. **SIGNATURE** — Supervising Provider	24. Date Signed

Reset Form