FORWARDHEALTH
PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA)

Providers may submit prior authorization (PA) requests 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 Day Treatment Attachment (PA/SADTA) Completion Instructions, F-11037A.

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. Telephone Number — Requesting / Rendering Provider

SECTION III — DOCUMENTATION

6. Describe length and intensity of treatment requested.

- Program request is for _________ hours per day,
  ________days per week,
  for ________weeks,
  for a total of ________hours.
- Anticipated beginning treatment date ______________________.
- Estimated substance abuse day treatment discharge date____________________.
- Attach a copy of treatment design, which includes the following:
  a. A schedule of treatment (day, time of day, length of session, and service to be provided during that time).
  b. A brief description of aftercare / continuing care / follow-up component (also include this information in the treatment plan section of this form).

7. List the dates of diagnostic evaluations or medical examinations and **specific** diagnostic procedures that were employed.

Continued

DT-PA051-051

SECTION III — DOCUMENTATION (Continued)

8. List the **current** primary and secondary diagnosis codes and descriptions from the most recent *Diagnostic and Statistical Manual of Mental Disorders* for the member's current primary and secondary diagnosis.

9. Describe the member's **current** clinical problems and relevant clinical history, including substance abuse history. (Give details of dates of abuse, substance[s] abused, amounts used, date of last use, etc.)

10. Has the member received any substance abuse treatment in the past 12 months? ❑ Yes ❑ No

    If "Yes," provide information on the date of each treatment episode, the type of service provided, and the **treatment outcomes**.

11. Has the member received any inpatient substance abuse care, intensive outpatient substance abuse services, or substance abuse day treatment in the past 12 months? ❑ Yes ❑ No

    If "Yes," give rationale for appropriateness and medical necessity of the current request. Describe projected outcome of additional treatment requested.

Continued

SECTION III — DOCUMENTATION (Continued)

12. Describe the member's severity of illness using the following indicators. Individualize all information.

    a. Loss of control / relapse crisis.

    b. Physical conditions or complications.

    c. Psychiatric conditions or complications. (Include psychiatric diagnosis, medications, current psychiatric symptoms.)

    d. Recovery environment.

    e. Life areas impairment. (Specify social / occupational / legal / primary support group.)

    f. Treatment acceptance / resistance.

13. Treatment Plan
    - **Attach** a copy of the member's substance abuse day treatment plan (refer to intensity of service guideline in the substance abuse day treatment criteria).
    - Describe any special needs of the member and indicate how these will be addressed (for example, educational needs, access to treatment facility).
    - Describe the member's family / personal support system. Indicate how these issues will be addressed in treatment, if applicable. If family members / personal support system are not involved in treatment, explain why not.

Continued

SECTION III — DOCUMENTATION (Continued)

13. Treatment Plan (Continued)

- Briefly describe treatment goals and objectives in specific and measurable terms.

- Describe the expected outcomes of treatment including the plan for continuing care.

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

14. SIGNATURE — Member or Representative	15. Date Signed
16. Relationship (If Representative)	
17. SIGNATURE — Rendering Provider	18. Date Signed
19. Discipline of Rendering Provider	
20. SIGNATURE — Supervising Physician or Psychologist	21. Date Signed
22. Supervising Physician or Psychologist's NPI	