**DEPARTMENT OF HEALTH SERVICES**
Division of Medicaid Services
F-11030 (02/2024)

**STATE OF WISCONSIN**
Wis. Admin. Code §§ DHS 107.24(3), DHS 152.06(3)(h), DHS 153.06(3)(g), DHS 154.06(3)(g)

**FORWARDHEALTH**

# PRIOR AUTHORIZATION / DURABLE MEDICAL EQUIPMENT ATTACHMENT (PA/DMEA)

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Durable Medical Equipment Attachment (PA/DMEA) Instructions, F-11030A. Prescribers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth through the Portal, by fax at 608-221-8616, or by mail to ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784.

## SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

| 2. Age – Member | 3. Member ID Number |
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## SECTION II – PROVIDER INFORMATION

4. Name – Prescribing Physician

5. National Provider Identifier – Prescribing Physician

| 6. Phone Number – Prescribing Physician | 7. Phone Number – Dispensing Provider |
|---|---|
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## SECTION III – SERVICE INFORMATION

8. Describe the overall physical status of the member (mobility, self-care, strength, and coordination).

9. Describe the medical condition of the member as it relates to the equipment or item requested (for example, describe why the member needs this equipment).

10. Is the member able to operate the equipment or item requested? ❑ Yes ❑ No

If not, who will do this?

11. Is training provided? ❑ Yes ❑ No

If yes, who will do this?

If no, explain why training is not required.

12. State where equipment or item will be used. (Choose all that apply.)

- ❑ Home
- ❑ Job
- ❑ Nursing Home
- ❑ Office
- ❑ School

Describe the accessibility of the places where the equipment will be used.

13. State estimated duration of need.

14. If renewal or continuation of DME authorization is requested, provide an update on the member's condition since the implementation of the prescribed item(s).

15. Indicate amount of oxygen to be administered.

_____ Liters per minute _____ Continuous

_____ Hours per day _____ PRN

_____ Days per week _____ $PaO_2$

Attach a photocopy of the physician's prescription to this attachment. The prescription must be signed and dated within one year of receipt by ForwardHealth.

| 16. **SIGNATURE** – Requesting Provider | 17. Date Signed |
|---|---|
| | |

Reset Form