FORWARDHEALTH
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for dental 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. The Prior Authorization Dental Request Form (PA/DRF), F-11035, is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers may submit PA requests, along with the Prior Authorization/Dental Attachment 1 (PA/DA1), F-11010, or the Prior Authorization/Dental Attachment 2 (PA/DA2), F-11014, by fax to ForwardHealth at (608) 221-8616. This option is available only when the PA request does not include additional documentation, such as dental models or X-rays. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Only non-paper documentation, such as dental models or X-rays, will be returned back to providers. Providers may submit PA requests with attachments 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).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck “Other Services” and Wisconsin Chronic Disease Program
Enter an “X” in the box next to HealthCheck “Other Services” if the services requested on the PA/DRF are for HealthCheck “Other Services.”

Enter an “X” in the box next to Wisconsin Chronic Disease Program (WCDP) if the services requested on the PA/DRF are for a WCDP member.

Element 2 — Process Type
Check the appropriate box to indicate the process type for either dental services (124) or orthodontic services (125).

Element 3 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 4 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP+4 code for timely and accurate PA processing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Element 5a — Billing Provider Number
Enter the National Provider Identifier (NPI) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the billing provider’s NPI in Element 5a.

Element 6a — Rendering Provider Number
Enter the NPI of the rendering provider, if it is different from the number in Element 5a. This is the provider who will actually perform the service.

Element 6b — Performing Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the rendering provider’s NPI in Element 6a.

SECTION II — MEMBER INFORMATION

Element 7 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or the Wisconsin Enrollment Verification System (EVS) to obtain the correct identification number.

Element 8 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format (e.g., September 8, 1966, would be 09/08/1966).

Element 9 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP+4 code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 10 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 11 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 12 — Place of Service
Check the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 13 — Dental Diagram
For partials, endodontics, and periodontics, enter an "X" next to the periodontal case type. On the dental diagram, cross out ("X") missing teeth (including extractions). Circle teeth to be extracted only when requesting endodontic or partial denture services. At the bottom of the element, indicate the number and type of X-rays submitted with this PA request.

Element 14 — Area of Oral Cavity
If the procedure applies to dentures, partials, or to periodontal procedures performed by quadrant, enter the appropriate two-digit area of the oral cavity from the list below.

01 — Maxillary Arch
02 — Mandibular Arch
10 — Upper Right Quadrant
20 — Upper Left Quadrant
30 — Lower Left Quadrant
40 — Lower Right Quadrant

Element 15 — Tooth
Using the numbers and letters on the dental diagram in Element 13, identify the tooth number or letter for the service requested.

Element 16 — Procedure Code
Enter the appropriate procedure code for each service/procedure/item requested.

Element 17 — Modifier
Enter the modifier corresponding to the procedure code listed if a modifier is required by ForwardHealth.

Element 18 — Description of Service
Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.

Element 19 — Quantity Requested
Enter the appropriate quantity requested for each procedure code listed.

Element 20 — Charge
Enter the usual and customary charge for each service/procedure/item requested.

Note: The charges indicated on the PA/DRF should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the provider *Terms of Reimbursement* issued by the Department of Health Services.

Element 21 — Total Charges
Enter the anticipated total charge for this request.

Element 22 — Signature — Rendering Provider
The original signature of the provider performing this service/procedure must appear in this element.

Element 23 — Date Signed
Enter the month, day, and year the PA/DRF was signed by the rendering provider (in MM/DD/CCYY format).

Element 24 — Signature — Member/Guardian (if applicable)
If desired, the member or member's guardian may sign the PA/DRF.

Element 25 — Date Signed
Enter the month, day, and year the PA/DRF was signed by the member or member's guardian (in MM/DD/CCYY format).