FORWARDHEALTH

PRIOR AUTHORIZATION / CARE PLAN ATTACHMENT (PA/CPA)

Instructions: Print or type clearly. Refer to the Required Information for Prior Authorization/Care Plan Attachment (PA/CPA), Completion Instructions, F-11096A, for information about completing this form.

SECTION I — MEMBER INFORMATION

1. Name — Member

2. Telephone Number — Member	3. Member Identification Number
4. Start of Care Date	5. Certification Period From To

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

6. Principal Diagnosis (*International Classification of Diseases* [ICD] Code, Description, Date of Diagnosis)

7. Surgical Procedure and Other Pertinent Diagnoses (ICD Code, Description, Date of Procedure or Diagnoses)

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

8. Durable Medical Equipment

9. Functional Limitations

1 ❑ Amputation
2 ❑ Bowel / Bladder (Incontinence)
3 ❑ Contracture
4 ❑ Hearing
5 ❑ Paralysis
6 ❑ Endurance
7 ❑ Ambulation
8 ❑ Speech
9 ❑ Legally Blind
10 ❑ Dyspnea with Minimal Exertion
11 ❑ Other (Specify other functional limitations in the space provided.)

10. Activities Permitted

1 ❑ Complete Bedrest
2 ❑ Bedrest BRP
3 ❑ Up As Tolerated
4 ❑ Transfer Bed / Chair
5 ❑ Exercises Prescribed
6 ❑ Partial Weight Bearing
7 ❑ Independent at Home
8 ❑ Crutches
9 ❑ Cane
10 ❑ Wheelchair
11 ❑ Walker
12 ❑ No Restrictions
13 ❑ Other (Specify other activities permitted in the space provided.)

Continued

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION (Continued)

11. Medications (Dose / Frequency / Route)

12. Allergies

13. Nutritional Requirements

14. Mental Status	1 ❑ Oriented	3 ❑ Forgetful	5 ❑ Disoriented	7 ❑ Agitated
	2 ❑ Comatose	4 ❑ Depressed	6 ❑ Lethargic	8 ❑ Other ___

15. Prognosis	1 ❑ Poor	2 ❑ Guarded	3 ❑ Fair	4 ❑ Good	5 ❑ Excellent

SECTION IV — ORDERS

16. Orders for Services and Treatments (Number / Frequency / Duration)

Continued

SECTION IV — ORDERS (Continued)

17. Goals / Rehabilitation Potential / Discharge Plans

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

18. Date Physician Last Saw Member	19. Dates of Last Inpatient Stay Within 12 Months (If Known) Admission Discharge	20. Type of Facility for Last Inpatient Stay (If Applicable)

21. Current Information (Summary from Each Discipline / Treatments / Clinical Facts)

22. Home or Social Environment

23. Medical and / or Nonmedical Reasons Member Regularly Leaves Home (Include Frequency)

Continued

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION (Continued)

24. Names of Other Providers with Whom This Case Is Shared

SECTION VI — SIGNATURES

Nurse Certification
As the nurse completing this plan of care (POC), I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form.

25. **SIGNATURE** — Authorized Registered Nurse (RN) Completing Form	26. Date Signed by Authorized RN Completing Form

27. Date of Verbal Orders for Initial Certification Period	28. Date Physician-Signed Form Received

Physician Certification
The member is under my care, and I have ordered the services on this POC.

29. Name and Address — Attending Physician (Street, City, State, ZIP+4 Code)

30. **SIGNATURE** — Attending Physician	31. Date Signed — Attending Physician

Case Sharing Provider
As a provider countersigning this POC, I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form.

32. **COUNTERSIGNATURE**	33. Date Countersigned

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.