DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11030 (07/12)

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

FORWARDHEALTH

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

Providers may submit prior authorization (PA) requests with 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/Durable Medical Equipment Attachment (PA/DMEA) Completion Instructions, F-11030A.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Age — Member
3. Member Identification Number	

SECTION II — PROVIDER INFORMATION

4. Name — Prescribing Physician	5. Prescribing Physician's National Provider Identifier
6. Telephone Number — Prescribing Physician	7. Telephone Number — Dispensing Provider

SECTION III — SERVICE INFORMATION

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

9. Describe the medical condition of the member as it relates to the equipment / item requested (e.g., describe why the member needs this equipment).

Continued

SECTION III — SERVICE INFORMATION (continued)

10. Is the member able to operate the equipment / item requested?

❑ Yes ❑ No — If not, who will do this?

11. Is training provided or required?

❑ Yes ❑ No — If not, who will do this?

Explain.

12. State where equipment / item will be used.

❑ Home ❑ Office
❑ Nursing Home ❑ Job
❑ School

Describe type of dwelling and accessibility.

13. State estimated duration of need.

14. If renewal or continuation of DME authorization is requested, describe the following about the member, including current clinical condition, progress (improvement, no change, etc.), results, and the member's use of equipment / item prescribed.

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 six months of receipt by ForwardHealth.

16. **SIGNATURE** — Requesting Provider	17. Date Signed

Reset Form