ATTACHMENT 4
Sample Prior Authorization Request Form (PA/RF) for spell of illness requests

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 116

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow St, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M [X] F [ ]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
Speech Therapist
1 W Williams
Anytown, WI 55555

9 BILLING PROVIDER NO: 12345678

10 DX: PRIMARY: 434.1 — cerebral embolism

11 DX: SECONDARY:

12 START DATE OF SOI: MM/DD/YY

13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
92526		3	1	dysphagia therapy		
92507		3	1	speech therapy		

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

TOTAL CHARGE 21

23 MM/DD/YY DATE

24 I.M. Authorized REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE [ ] EXPIRATION DATE [ ] PROCEDURE(S) AUTHORIZED [ ] QUANTITY AUTHORIZED

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

460-120