Attachment A-7a

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

ELEMENT 1 - PROCESSING TYPE
Enter the appropriate three digit processing type from the attached table. The 'process type' is a three digit code used to identify the type of service requested. Use 999 - 'Other' only if the request cannot reference any of the process types listed. Prior Authorization/Spell of Illness requests will be returned without adjudication if no processing type is indicated.

**111 - Physical Therapy
**112 - Occupational Therapy
**113 - Speech Therapy/Audiology
**114 - Physical Therapy (spell of illness only)
**115 - Occupational Therapy (spell of illness only)
**116 - Speech Therapy (spell of illness only)
117 - Physician Services (includes Family Planning and Rural Health)
118 - Chiropractic
*120 - Home Health/Independent Nurses Services/Home Health Therapy
121 - Personal Care Services
122 - Vision
126 - Psychotherapy (HCFA 1500 billing providers only)
127 - Psychotherapy (UB82 billing providers only)
128 - AODA Services
129 - Day Treatment Services
130 - Durable Medical Equipment
131 - Drugs
132 - Disposable Medical Supplies
133 - Transplant Services
134 - AIDS Services (hospital and nursing home)
135 - Ventilator Services (hospital and nursing home)
999 - Other (use only if the request cannot reference any of the processing types listed)

* Includes PT, OT, Speech
** Includes Rehabilitation Agencies

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the ten digit medical assistance recipient number as found on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence, the street, city, state and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

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ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (i.e., June 8, 1941 would be 06/08/41), as it appears on the recipient's medical assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an 'X' to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state and zip code) of the billing provider. No other information should be entered in this element, as this element also serves as your return address label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit WMAP provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

> **NOTE:**
> Pharmacists, medical vendors and individual medical suppliers may provide a written description only.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition.

> **NOTE:**
> Pharmacists, medical vendors and individual medical suppliers may provide a written description only.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS*
DO NOT COMPLETE THIS ELEMENT UNLESS REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS. Enter the date of onset for the spell of illness in MM/DD/YY format (i.e., March 1, 1988 would be 03/01/88).

* Therapy spell of illness requests only.

ELEMENT 13 - FIRST DATE OF TREATMENT*
DO NOT COMPLETE THIS ELEMENT UNLESS REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (i.e., March 1, 1988 would be 03/01/88).

* Therapy spell of illness requests only.

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate revenue, HCPCS or national drug code (NDC) procedure code for each service/procedure/item requested, in this element. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 15 - MODIFIER
Enter the modifier for the procedure code (if a modifier is required by Bureau of Health Care Financing policy and the coding structure used) for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code designating where the requested service/procedure/item will be provided/performed/dispensed.

Code	Description
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility
9	Ambulance

Alpha	Description
A	Independent Lab

NOTE:
Mental health services may not be provided in the recipient's home (POS 4).

ELEMENT 17 - TYPE OF SERVICE
Enter the appropriate type of service code for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

Numeric	Description
0	Blood
1	Medical (including: Physician's Medical Services, Home Health,
2	Surgery Independent Nurses, Audiology, PT, OT, ST, Personal
3	Consultation Care, AODA, and Day Treatment)
4	Diagnostic X-Ray - Total Charge
5	Diagnostic Lab - Total Charge
6	Radiation Therapy - Total Charge
7	Anesthesia
8	Assistant Surgery
9	Other including:
	Transportation
	*Non-MD Psych
	Family Planning Clinics
	Rehabilitation Agency
	Nurse Midwife
	Chiropractic

* non-board operated only

Alpha	
B	Diagnostic Medical - Total
C	Ancillaries, Hospital and Nursing Home
D	Drugs
E	Accommodations, Hospital and Nursing Home
F	Free Standing Ambulatory Surgical Center
G	Dental
J	Vision Care and Cataract Lens
K	Nuclear Medicine - Total Charge
P	Purchase New DME
Q	Diagnostic X-Ray - Professional
R	DME Rental
S	Radiation Therapy - Professional
T	Nuclear Medicine - Professional
U	Diagnostic X-Ray, Medical - Technical
W	Diagnostic Medical - Professional
X	Diagnostic Lab - Professional

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate revenue, HCPCS or National Drug Code (NDC) procedure code for each service/procedure/item requested.

NOTE:
If you are requesting a therapy spell of illness, enter 'Spell of Illness' in this element.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (sessions, number of services, etc.) requested for each service/procedure/item requested.

AODA Services (number of services)
Audiology Services (number of services)
Chiropractic (number of manipulations)
Day Treatment Services (number of services)
Dental (number of services)
Disposable Medical Supplies (number of days supply)
Drugs (number of days supply)
Durable Medical Equipment (number of services)
Hearing Aid (number of services)
Home Health (number of units)/Independent Nurses (number of units)
Services/Home Health Therapy-PT, OT, Speech (number of visits)
Hospital Transplant Services (per hospital stay)
Hospital and Nursing Home AIDS Services (number of days)
Hospital and Nursing Home Ventilator Services (number of days)
Occupational Therapy (number of services)
Occupational Therapy (spell of illness only) (enter 45)
Orthodontics (dollar amount)
Personal Care Services (number of hours)
Physical Therapy (number of services)
Physical Therapy (spell of illness only) (enter 45)
Physician Services (number of services)
Psychotherapy (HCFA 1500 billing providers only) (number of services)
Psychotherapy (UB82 billing providers only) (dollar amount)
Speech Therapy (number of services)
Speech Therapy (spell of illness only) (enter 45)
Vision (number of services)

NOTE:
If requesting a therapy spell of illness, enter '45' in this element.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

> **NOTE:**
> The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Approval of a prior authorization is for the service only. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health & Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 22 - BILLING CLAIM CLARIFICATION STATEMENT
'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 date 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.'

ELEMENT 23 - DATE
Enter the month, day and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER -- THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).