INSTRUCTIONS FOR THE COMPLETION OF
THE PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT
(PA/SOIA)
(Physical, Occupational, Speech Therapy)

Do not use this attachment to request prior authorization to extend treatment beyond forty-five treatment days for the same spell of illness, use the Prior Authorization Therapy Attachment (PA/TA).

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization for a spell of illness. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Spell of Illness Attachment (PA/SOIA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the recipient's ten digit medical assistance number exactly as it appears on the recipient's medical assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (i.e., 45, 60, 21, etc.).

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PROVIDER INFORMATION:

ELEMENT 6 - THERAPIST'S NAME AND CREDENTIALS
Enter the name and credentials of the primary therapist who would be responsible for and participate in therapy services for the recipient. If the performing provider will be a therapy assistant, enter his/her name and credentials, also enter the name of the supervising therapist.

ELEMENT 7 - THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit medical assistance provider number of the therapist who would provide the authorized service (performing provider). If the performing provider will be a therapy assistant, enter his/her medical assistance provider number, also enter the medical assistance provider number of the supervising therapist.

ELEMENT 8 - THERAPIST'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the therapist who would provide the authorized service (performing provider). If the performing provider would be a therapy assistant, enter his/her telephone number and the telephone number of the supervising therapist.

ELEMENT 9 - REFERRING/PRESCRIBING PHYSICIAN'S NAME
Enter the name of the physician referring/prescribing evaluation/ treatment.

PART A
Enter an 'X' in the appropriate box to indicate a physical, occupational or speech therapy spell of illness request.

PART B
Enter a description of the recipient's diagnosis and problems. Indicate what functional regression has occurred and what the potential to reachieve the previous skill is.

PART C
Attach a copy of the recipient's Therapy Plan of Care, including a current dated evaluation to the Spell of Illness Attachment before submitting the spell of illness request.

Attachment A-8c

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PART D
Enter the anticipated end date of the spell of illness in the space provided.

PART E
Attach the physician's dated signature on either the Therapy Plan of Care or copy of physician's order sheet to this attachment.

Read the Prior Authorization Statement before dating and signing the Attachment.

PART F
The signature of the prescribing physician and the date must appear in the space provided. (A signed copy of the Physician's order sheet is acceptable.)

PART G
The dated signature of the therapist providing evaluation/treatment must appear in the space provided.