ATTACHMENTS
FAMILY PLANNING SERVICES

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Family Planning Services

FORM APPROVED
OMB NO. 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

[ ] MEDICARE (MEDICARE NO.) [P] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Recipient Im A.
2. PATIENT'S DATE OF BIRTH: MM | DD | YY
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Same
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown WI 53725
5. PATIENT'S SEX: MALE [ ] FEMALE [X]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS): 1234567890
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.) [ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

TELEPHONE NO.

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER): OI - R
10. WAS CONDITION RELATED TO:
   - A. PATIENT'S EMPLOYMENT: YES [ ] NO [X]
   - B. ACCIDENT: AUTO [ ] OTHER [X]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

11a. CHAMPUS SPONSOR'S STATUS: [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED; BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW

SIGNED / DATE / / / / / / / /

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON) / / / / / / / /

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES / / / / / / / / / / /
16a. IF EMERGENCY CHECK HERE [ ]
17. DATE PATIENT ABLE TO RETURN TO WORK / / / / / / /
18. DATES OF TOTAL DISABILITY: FROM / / / / / / / / THROUGH / / / / / / / / /

DATES OF PARTIAL DISABILITY: FROM / / / / / / / / THROUGH / / / / / /

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY): I. M. Prescribing 12345678
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED | DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
   1. V25.1
   2. V25.4
   3.
   4.

B. EPSDT: YES [ ] NO [X]; FAMILY PLANNING: YES [X] NO [ ]

PRIOR AUTHORIZATION NO.

24 A DATE OF SERVICE FROM TO	B* PLACE OF SERVICE	C PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G* TOS	H LEAVE BLANK
01/30/88	3	W6200	IUD	1	XXXX	1.0	9	
02/22/88	3	90040	OFFICE VISIT	2	XXXX	1.0	9	
								Patient Spenddown $

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

DATE MM/DD/YY I.M. PROVIDER

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) / / YES [ ] / [ ] NO / /
27. TOTAL CHARGE: XX XX
28. AMOUNT PAID: XX XX
29. BALANCE DUE: XX.XX
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.: I.M. Billing, 1 W Williams, Anytown WI 53725; I.D. NO. 87654321
32. YOUR PATIENT'S ACCOUNT NO.: 1234JED
33. YOUR EMPLOYER I.D. NO. / / / / / / / / / / / /

* PLACE OF SERVICE AND TYPE OF SERVICE (TOS) CODES ON THE BACK

REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500 CHAMPUS-501 Form RRB-1500

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FAMILY PLANNING CLINIC SEVICES

* *

To avoid unnecessary denial or inaccurate claim payment, providers must utilize the following claim form completion instructions. Enter all required data on the face of the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless 'optional' or 'not required' is specified.

Wisconsin medical assistance recipients receive a medical assistance ID card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. This card should always be presented prior to rendering the service. Please use the information exactly as it appears on the ID card to complete the information in the Patient and Insured (Subscriber) Information section.

Program Block/Claim Sort Indicator

Enter the appropriate **CLAIM SORT INDICATOR** for the service billed in the Medicaid check box in the upper left-hand corner of the claim form. Claims submitted without this indicator are denied.

'D' - Corrective Shoes
- Durable Medical Equipment (unless dispensed by a therapist)
- Hearing Aids

'M' - Independent Nurse
- Mental Health - 51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Nurse Midwife
- Rehabilitation Agency
- Community Care Organization

'P' - Chiropractor
- Family Planning Clinic
- Free Standing Ambulatory Surgery Center

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FAMILY PLANNING CLINIC SEVICES

* *

'P' - Independent Laboratory and Radiology
- Mental Health - Non-51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Physician
- Rural Health Agency

'T' - Therapy - Occupational, Physical, Speech and Hearing
- Durable Medical Equipment Dispensed by Occupational, Physical or Speech Therapist

'V' - Vision - Optometrist, Optician, Dispensing Ophthalmologist

ELEMENT 1 - PATIENT NAME
Enter the recipient's last name, first name and middle initial as it appears on his/her current medical assistance identification card.

ELEMENT 2 - PATIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., January 5, 1978 would be 01/05/78) as it appears on his/her medical assistance identification card.

ELEMENT 3 - INSURED'S NAME
If the recipient's name (element #1) and insured's name (element #3) are the same, enter 'SAME' or leave the element blank.

ELEMENT 4 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence; if the recipient is a resident of a nursing home, enter the name and address of the nursing home.

ELEMENT 5 - PATIENT'S SEX
Specify if male or female with an 'X'.

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FAMILY PLANNING CLINIC SEVICES

* *

ELEMENT 6 - INSURED'S ID NUMBER

Enter the recipient's ten digit medical assistance ID number as found on his/her medical assistance identification card.

ELEMENT 7 - PATIENT'S RELATIONSHIP TO INSURED (not required)

ELEMENT 8 - INSURED'S GROUP NUMBER (not required)

ELEMENT 9 - OTHER INSURANCE

Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP if the service is one of those identified in the Billing Information section of the WMAP Provider Handbook, Part A. When the recipient's medical assistance card indicates other coverage, one of the following codes MUST be indicated. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by other insurance
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, non-covered service, etc.
OI-C	Recipient or other party will NOT COOPERATE
OI-S	SENT claim, but insurance company did not respond
OI-R	RECIPIENT denies coverage
OI-E	ERISA plan denies being prime
OI-A	Benefits NOT ASSIGNABLE
OI-H	Denied payment. Private health maintenance organization (HMO) or health maintenance plan (HMP) denied payment due to one of the following: non-covered/family planning service, or paid amount applied to the recipient's coinsurance/deductible.

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FAMILY PLANNING CLINIC SEVICES

* *

If the recipient's medical assistance card indicates no other coverage, the element may be left blank.

ELEMENT 10 - IS CONDITION RELATED TO
If the condition is the result of an employment-related, auto or other accident, enter an 'X' in the appropriate box for items 'A' and 'B'.

ELEMENT 11 - INSURED'S ADDRESS
This element is used by the WMAP for Medicare information. Medicare must be billed prior to the WMAP. When the recipient's medical assistance card indicates Medicare coverage, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Service denied/rejected by Medicare
M-8	Not a Medicare benefit

If the recipient's medical assistance card indicates no Medicare coverage, this element may be left blank.

ELEMENT 11A - (not required)

ELEMENTS 12 - 13
(Not required, provider automatically accepts assignment through medical assistance certification.)
ELEMENT 14 - DATE OF ILLNESS OR INJURY (not required)

ELEMENT 15 - DATE FIRST CONSULTED FOR CONDITION (not required)

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FAMILY PLANNING CLINIC SEVICES

* *

ELEMENT 16 - (not required)

ELEMENT 16A - EMERGENCY
Enter an 'X' if emergent.

ELEMENT 17 - (not required)

ELEMENT 18 - (not required)

ELEMENT 19 - REFERRING PHYSICIAN
This is a required element. Enter the referring/prescribing physician's name and, if available, the eight digit medical assistance number.

ELEMENT 20 - HOSPITALIZATION DATES (not required)

ELEMENT 21 - NAME AND ADDRESS OF FACILITY (not required)

ELEMENT 22 - LAB WORK, PLACE OF SERVICE (not required)

ELEMENT 23A - DIAGNOSIS
The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ('E') codes may not be used as a primary diagnosis.

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FAMILY PLANNING CLINIC SEVICES

* *

ELEMENT 23B - EPSDT/FAMILY PLANNING INDICATOR/PRIOR AUTHORIZATION NUMBER

EPSDT

If the services were performed as a result of an EPSDT/HealthCheck referral, check 'YES'; otherwise check 'NO'. EPSDT/HealthCheck indicators may not be left blank; a positive or negative response must be indicated.

Family Planning

If the recipient is receiving family planning services only, enter an 'X' in 'YES'. If none of the services are related to family planning, enter an 'X' in 'NO'.

NOTE: If the services reported are a combination of family planning services and services related to other diagnoses, the family planning indicators must be left blank.

To ensure accurate reporting of family planning services (enabling the State to receive Federal Financial Participation monies), the Diagnosis Code Reference must be utilized. Please refer to 'Diagnosis Code Reference' - element 24D for detailed instructions on the use of this claim form element.

Prior Authorization

The seven digit prior authorization number from the approved prior authorization form must be entered in element 23B. Do not attach a copy of the prior authorization to the claim. Services authorized under multiple prior authorizations must be billed on separate claims.

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FAMILY PLANNING CLINIC SEVICES

* *

ELEMENT 24 - SERVICES

<u>Element 24A - Date of Service</u>
In column A, enter the month, day and year in MMDDYY format for each procedure. It is allowable to enter up to four dates of service per line item for each procedure if:

* All dates of service are in the same calendar month.
* All procedures performed are identical.
* All procedures were performed by the same provider.
* The place and type of service is identical for all procedures.
* The same diagnosis is applicable for each procedure.
* The charge for all procedures is identical. (Enter the charge <u>per service</u> following the description in element 24C.)
* The number of services performed on each date of service is identical.

<u>Element 24B - Place of Service</u>
Enter the appropriate place of service code in column B for each service. Refer to Attachment 4 of this bulletin for a list of allowable place of service codes for family planning clinic providers.

<u>Element 24C - Procedure Code and Description</u>
Enter the appropriate procedure code and matching description for each service performed. Enter a written description which is concise, complete and specific for each billed service.

<u>Element 24D - Diagnosis Code Reference</u>
When multiple procedures related to different diagnoses are submitted, column D must be utilized to relate the procedure performed (element 24C) to a specific diagnosis in element 23A.

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FAMILY PLANNING CLINIC SEVICES

* *

The diagnosis code itself may be entered in column D, or enter the line number from element 23A (i.e., 1, 2, 3 or 4) of the appropriate diagnosis as shown on the claim example.

Element 24E - Charges

Enter the total charge for each line item.

Element 24F - Days or Units

Enter the total number of services billed on each line item.

Element 24G - Type of Service (TOS)

Enter the appropriate type of service code. Refer to Attachment 4 of this bulletin for a list of allowable type of service codes for family planning clinic providers.

Element 24H - Recipient Spenddown

Enter the spenddown amount, when applicable, on the last detail line of element 24H directly above element 29. Refer to MAPB-087-037-X dated September 1, 1987 for information on recipient spenddown.

ELEMENT 25 - PROVIDER SIGNATURE AND DATE

The provider or the authorized representative must sign in element 25. The month, day and year the form is signed must also be entered.

NOTE: This may be a computer printed name and date, or a signature stamp.

ELEMENT 26 -

(Not required, provider automatically accepts assignment through medical assistance certification.)

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FAMILY PLANNING CLINIC SEVICES

* *

ELEMENT 27 - TOTAL CHARGE

Enter the total charges for this claim.

ELEMENT 28 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00.

ELEMENT 29 - BALANCE DUE

Enter the balance due as determined by subtracting the amount in element 24H and element 28 from the amount in element 27.

ELEMENT 30 - (not required)

ELEMENT 31 - PROVIDER NAME AND ID NUMBER

Enter the name, address, city, state and zip code of the billing provider. At the bottom of element 31 enter the billing provider's eight digit provider number.

ELEMENT 32 - PATIENT ACCOUNT NUMBER

Optional - provider may enter the patient's internal office account number. This number will appear on the EDS Remittance and Status Report (maximum of twelve characters).

ELEMENT 33 - (not required)

ATTACHMENT 3

HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE FOR FAMILY PLANNING CLINIC SERVICES

The HCFA Common Procedure Code System (HCPCS) is required for claims submitted on and after January 1, 1988. Please refer to the following table.

PROCEDURE CODE		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
09917	W6200	n/a	Intrauterine Device	n/a
09918	W6201	n/a	Diaphragm	n/a
09919	W6202	n/a	Jellies, Creams, Foams	n/a
09919	W6203	n/a	Suppositories (per 1)	n/a
09919	W6204	n/a	Sponges (per 1)	n/a
09920	W6205	n/a	Condoms (per 1)	n/a
09921	W6206	n/a	Natural Family Planning Supplies (charts)	n/a
09995	W6210	n/a	Family Planning Pharmacy Visit	n/a
90020	90020	n/a	Initial Physical Examination	n/a
90030	90030	n/a	Follow-up Visit - Nurse	n/a
90040	90040	n/a	Follow-up Visit - Physician	n/a
90080	90080	n/a	Annual Physical Examination	n/a

ATTACHMENT 4

FAMILY PLANNING CLINIC SERVICES

* *

PLACE OF SERVICE (POS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
1	3	Office

TYPE OF SERVICE (TOS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
9	9	Other (including family planning)

ATTACHMENT 5

PRIOR AUTHORIZATION REQUEST FORMS AND USAGE

All requests for prior authorization received on and after January 1, 1988 must be submitted on the following revised forms. Refer to the following chart for the appropriate request and attachment forms to be used when requesting authorization for specific services.

Service	Prior Authorization Form Required	Special Consideration
Chiropractic	Prior Authorization Request Form (PA/RF) & Chiropractic (PA/CA)	Use when requesting prior authorization to extend treatment beyond twenty manipulations per spell of illness.
Dental/Orthodontia	Dental Prior Authorization Request Form (PA/DRF) & Dental Services Attachment (PA/DA)	Do not complete PA/DA if requesting orthodontic services.
	Dental Prior Authorization Request Form (PA/DRF) & Orthodontic Services Attachment (PA/OA)	Use to report orthodontic services only.
Drug DME DMS (includes PT, OT, Speech and Home Health DME)	Prior Authorization Request Form (PA/RF) & Drug/Disposable Medical Supplies Attachment (PA/DGA)	- Use to request any drug requiring prior authorization. - Use to request disposable medical supply item requiring prior authorization.
	Prior Authorization Request Form (PA/RF) & Durable Medical Equipment (PA/DMEA)	Use to request any DME item requiring prior authorization.
Hearing Aid	Physicians Otological Report (PA/OF)	Must be completed by referring physician. Audiologist must submit PA/OF with PA/ARF1 and PA/ARF2 when requesting authorization for hearing aid(s).

Prior Authorization
Request Forms and Usage
Page 2

Service	Prior Authorization Form Required	Special Consideration
Hearing Aid (continued)	Audiological Report for Hearing Aid Request (PA/ARF1) & Hearing Aid Request Form (PA/ARF2)	Audiologists uses PA/ARF1 and PA/ARF2 to request hearing aid (must also include PA/OF).
Home Health (includes Independent Nurses)	Prior Authorization Request Form (PA/RF) & Home Health Attachment (PA/HHSA)	- Use to request home health aide/RN/LPN services provided by a home health agency. - Use to request nursing services provided by RN/LPN in independent practice.
	Prior Authorization Request Form (PA/RF) & Home Health Attachment (PA/HHTA)	- Use to request therapy (PT, OT, Speech) services provided by a home health agency.

NOTE:

1. If recipient will receive <u>only</u> home health therapy services, attach to the Prior Authorization Request Form (PA/RF) and submit to EDS.

2. If recipient will receive home health services <u>in addition</u> to home health therapy services, attach <u>both</u> attachment forms (PA/HHSA and PA/HHTA) to the Prior Authorization Request Form (PA/RF) and submit to EDS.

Hospital	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting prior authorization for - transplants - AIDS services - ventilator services
Mental Health	Prior Authorization Request Form (PA/RF) & Psychotherapy Attachment (PA/PSYA)	Use to request all psychotherapy services requiring prior authorization.

Prior Authorization
Request Forms and Usage
Page 3

Service	Prior Authorization Form Required	Special Consideration
Mental Health (continued)	Prior Authorization Request Form (PA/RF) & AODA Attachment (PA/AA) (Alcohol and Other Drug Abuse)	Use to request all AODA services requiring prior authorization.
	Prior Authorization Request Form (PA/RF) & Day Treatment Attachment (PA/DTA)	Use to request day treatment services requiring prior authorization.
Out-of-State	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting out-of-state nursing home services (process type 999).
Personal Care	Prior Authorization Request Form (PA/RF) & Personal Care Attachment (PA/PCA)	Use to request any personal care services requiring prior authorization.
Physician (includes family planning and rural health clinics)	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting any physician service requiring prior authorization.
Therapy (includes Rehabilitation Agencies)	Prior Authorization Request Form (PA/RF) & Therapy Attachment (PA/TA) (physical, occupational, speech and audiological)	Do not complete PA/TA when requesting a spell of illness (complete PA/SOI). Use PA/TA when requesting prior authorization to extend treatment beyond forty-five treatment days for the <u>same</u> spell of illness.
	Prior Authorization Request Form (PA/RF) & Spell of Illness Attachment (PA/SOI) (physical, occupational, speech)	Use to request a new spell of illness <u>only</u>.

Prior Authorization
Request Forms and Usage
Page 4

Service	Prior Authorization Form Required	Special Consideration
Transportation	Prior Authorization Request Form (PA/RF) & Physician Attachment (PA/PA)	Use when requesting any transportation service requiring prior authorization (process type 999).
Vision	Prior Authorization Request Form (PA/RF) & Vision Attachment (PA/VA)	Use to request any vision service requiring prior authorization.

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

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

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. #

1. PROCESSING TYPE

2. RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER

3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)

4. RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)

5. DATE OF BIRTH

6. SEX M ☐ F ☐

7. BILLING PROVIDER TELEPHONE NO. ( )

8. BILLING PROVIDE NAME, ADDRESS, ZIP CODE:

9. BILING PROVIDER NO.

10. DX: PRIMARY

11. DX: SECONDARY

12. START DATE OF SOI:

13. FIRST DATE Rx

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
					TOTAL CHARGE	21

An approved authorization does not guarantee payment. Reimbusement 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.

22. _____ DATE

23. _____ REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE _____ EXPIRATION DATE _____

PRODEDURE(S) AUTHORIZED QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

_____ DATE

_____ CONSULTANT/ANALYST SIGNATURE

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
**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 Clinic 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.

Instructions for the Completion of the
Prior Authorization Request Form (PA/RF)
Page 2

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.

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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).

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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, Independent Nurses, Audiology, PT, OT, ST, Personal Care, AODA and Day Treatment)
2	Surgery
3	Consultation
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 Clinic 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

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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 (number of services)
Chiropractic (number of adjustments)
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 sessions)
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.

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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).

MAPB-087-006-P
Date: 9/1/87

Mail To:

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

PA/PA

PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

1	2	3	4	5
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

6	7	8
PERFORMING PROVIDER'S NAME	PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	( ) - PERFORMING PROVIDER'S TELEPHONE NUMBER

9

REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. Describe diagnosis and clinical condition pertinent to service or procedure requested:

B. Describe medical history pertinent to service or procedure requested.

C. Supply justification for service or procedure requested.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

D. _____ _____

Date Requesting Provider's Signature

INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. 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 Physician Attachment (PA/PA) 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.).

PROVIDER INFORMATION:

ELEMENT 6 - PERFORMING PROVIDER'S NAME
Enter the name of the provider who would perform/provide the requested service/procedure.

Instructions for the Completion of the
Prior Authorization Physician Attachment
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ELEMENT 7 - PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight digit medical assistance provider number of the provider who would perform/provide the requested service/procedure.

ELEMENT 8 - PERFORMING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the performing provider.

ELEMENT 9 - REFERRING/PRESCRIBING PHYSICIAN'S NAME
Enter the name of the referring/prescribing physician in this element.

* *

The remaining portions of this attachment are to be used to document the justification for the requested service/procedure.

1. Complete elements A through D.

2. Read the Prior Authorization Statement before dating and signing the request.

3. Date and sign the attachment.