INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) FOR A SPELL OF ILLNESS (Physical, Occupational, Speech Therapy)

ELEMENT 1 - PROCESS TYPE
Enter the appropriate three digit process type in this element. Spell of illness requests will be returned without adjudication if no process type is indicated.

114 - Physical Therapy Spell of Illness
115 - Occupational Therapy Spell of Illness
116 - Speech Therapy Spell of Illness

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the ten digit medical assistance recipient number exactly as it appears 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.

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) exactly 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 it also serves as a return mailing 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 medical assistance provider number of the billing provider.

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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 spell of illness.

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 condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS
Enter the date of onset for the new spell of illness in MM/DD/YY format (i.e., March 1, 1988 would be 03/01/88).

ELEMENT 13 - FIRST DATE OF TREATMENT (SPELL OF ILLNESS)
Enter the date of the first treatment or evaluation for the new spell of illness in MM/DD/YY format (i.e., March 9, 1988 would be 03/09/88).

ELEMENT 14 - PROCEDURE CODE(S)
(leave this element blank)

ELEMENT 15 - MODIFIERS
(leave this element blank)

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code (3 - Office, 4 - Home, 7-Nursing Home, 8 - Skilled Nursing Facility).

ELEMENT 17 - TYPE OF SERVICE
(leave this element blank)

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter the description 'Spell of Illness' in this element.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter '45' in this element, signifying forty-five treatment days.

ELEMENT 20 - CHARGES
(leave this element blank)

ELEMENT 21 - TOTAL CHARGES
(leave this element blank)

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ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
Please read the 'Billing Claim Payment Clarification Statement' printed on the request before dating and signing the prior authorization request form.

> '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 (WMAP) 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 the request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider (therapist) requesting the spell of illness must appear in this element.