APPENDIX 9

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

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:

EDS
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 AODA Attachment (PA/AA) 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 AND CREDENTIALS
Enter the name and credentials of the therapist who will be providing treatment.

ELEMENT 7 - PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the performing provider. (Not required for providers in 51.42 Board-operated clinics.)

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

ELEMENT 9 - REFERRING/PRESCRIBING PROVIDER'S NAME
Enter the eight-digit Medical Assistance provider number of the provider referring/prescribing treatment. If the provider is not WMAP-certified, enter the provider's name.

ELEMENT 10 - REFERRING/PRESCRIBING PROVIDER'S NUMBER
Enter the eight-digit Medical Assistance provider number of the referring/prescribing provider, if available.

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

- PART A - Designate the type of treatment requested (i.e., primary intensive outpatient treatment; aftercare/follow-up service or affected family member/co-dependency treatment). Identify the types of sessions, duration and schedule. The total hours must match the quantity(ies) indicated on the PA/RF.

  If a certified psychotherapist is requesting specific psychotherapy services for the AODA-affected recipient that are not represented by the categories of treatment listed, complete the Prior Authorization Psychotherapy Attachment (PA/PSYA).

- PART B - Complete elements 1-10.

Providers may attach copies of assessments, treatment summaries, treatment plans or other documentation in response to the information requested on the form. Providers are responsible for ensuring that the information attached adequately responds to what is requested.

1. Attach a copy of the signed and dated prescription for AODA services. The initial presentation must be dated and signed within three months of receipt by EDS. Subsequent prescriptions must be dated within twelve months of receipt by EDS.

   NOTE: If a physician will be the performing provider, a prescription need not be attached.

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

3. The recipient's signature is optional.

4. The attachment must be dated and signed by the provider requesting/providing the service.

   NOTE: The name and signature of the supervising provider is not required if the performing provider is a physician or psychologist.