

**FORWARDHEALTH
PRIVATE DUTY NURSING PRIOR AUTHORIZATION ACKNOWLEDGEMENT**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number, Wis. Admin. Code § DHS 104.02(4).

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory.

INSTRUCTIONS

1. Allow the member, or member's parent, guardian, or legal representative, to read the plan of care and PA request. Answer any questions the member may have.
2. Have the member or the member's legal representative sign and date this form.
3. Attach this completed form to the Prior Authorization Request Form (PA/RF), F-11018, and/or Prior Authorization Amendment Request, F-11042. Providers should make duplicate copies of all paper documents mailed to ForwardHealth.
4. For more information on private duty nursing documentation, contact Provider Services at 800-947-9627.

Name — Member	Member Identification Number
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I have read the attached Plan of Care and the PA request.

Name — Person Signing Form (Print)	Relationship to Member (If Person Signing Form Is Not Member)
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SIGNATURE — Person Signing Form Check one of the following to identify person signing form. <input type="checkbox"/> Member <input type="checkbox"/> Member's Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Legal Representative	Date Signed
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