**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-11052A (10/08)

**STATE OF WISCONSIN**
HFS 107.24(3), Wis. Admin. Code

# FORWARDHEALTH
## STAT-PA ORTHOPEDIC SHOES WORKSHEET INSTRUCTIONS

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 (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., 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 service.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request. Providers should make duplicate copies of all paper documents mailed to ForwardHealth.

## SECTION I — MEMBER INFORMATION

### Element 1 — Name — Member
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

### Element 2 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

### Element 3 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

## SECTION II — PROVIDER INFORMATION

### Element 4 — Provider Name
Enter the name of the provider.

### Element 5 — National Provider Identifier
Enter the National Provider Identifier.

## SECTION III — CLINICAL INFORMATION FOR ORTHOPEDIC SHOES

### Element 6 — Prescription Signature Date
Enter the date the prescription was signed.

### Element 7
Check the appropriate box to indicate whether or not the member has received orthopedic shoes in the past. If "yes," proceed to the next question. If "no," proceed to Element 15.

### Element 8
Check the appropriate box to indicate whether or not the member wore orthopedic shoes to the pedorthic examination. If "yes," proceed to the next question. If no, the PA request requires additional information. The provider should submit the PA request on paper with complete clinical documentation.

### Element 9
Check the appropriate box to indicate whether or not the member's current shoes are in disrepair. If "yes," proceed to the next question. If no, the PA request requires additional information. The provider should submit the PA request on paper with complete clinical documentation.

**Element 10**
Check the appropriate box to indicate whether or not the requested shoes are manufactured by Drew, P.W. Minor, Markell, or Apex. If yes, proceed to the next question. If no, the PA request requires additional information. The provider should submit the PA request on paper with complete clinical documentation.

**Element 11 — Mobility Level**
Enter the Mobility Level that best describes the member (either "1," "2," or "3").

**Element 12 — Diagnosis Level**
Enter the Diagnosis Level that best describes the member (either "1," "2," "3," or "4").

**Element 13 — Need Level Number**
Enter the member's nine-digit Need Level (NDL) number. (Use a "1" to indicate "yes" or a "2" to indicate "no.")

## SECTION IV — FOR PROVIDERS USING STAT-PA

**Element 14 — Procedure Code of Product Requested**
Enter **one** requested procedure code per STAT-PA request. For touch-tone telephone users, the code will be entered as follows:
L3216 = *53 3 2 1 6  L3221 = *53 3 2 2 1   A5500 = *21 5 5 0 0

**Element 15 — Diagnosis Code**
Use the most appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code. For STAT-PA, the decimal is not necessary; however, all digits of the code must be entered.

**Element 16 — Place of Service**
Enter the appropriate place of service code designating where the requested product would be provided.

| Code | Description |
|------|-------------|
| 05 | Indian Health Service Free-Standing Facility |
| 06 | Indian Health Service Provider-Based Facility |
| 07 | Tribal 638 Free-Standing Facility |
| 08 | Tribal 638 Provider-Based Facility |
| 11 | Office |
| 12 | Home |
| 20 | Urgent Care Facility |
| 31 | Skilled Nursing Facility |
| 32 | Nursing Facility |
| 33 | Custodial Care Facility |
| 34 | Hospice |
| 50 | Federally Qualified Health Center |
| 54 | Intermediate Care Facility/Mentally Retarded |
| 71 | State or Local Public Health Clinic |
| 72 | Rural Health Clinic |

**Element 17 — Requested First Date of Service**
Enter the requested first date of service (DOS) for the product. For STAT-PA, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 18 — Total Number Requested**
Enter the total number of products being requested.

**Element 19 — Assigned Prior Authorization Number**
Record the PA number assigned by the STAT-PA system.

**Element 20 — Grant Date**
Record the grant date of the PA as assigned by the STAT-PA system.

**Element 21 — Expiration Date**
Record the date that the PA expires as assigned by the STAT-PA system.

## SECTION V — SIGNATURE

**Element 22 — SIGNATURE — Provider**
The provider must sign this element.

**Element 23 — Date Signed**
Enter the date signed in MM/DD/CCYY format.

## SECTION VI — ADDITIONAL INFORMATION

**Element 24**
Indicate any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.