

AT RISK PREGNANCY (ARP) MEDICAL INFORMATION / VERIFICATION FORM

Draft revised 12-14-09

Dear Physician,

The purpose of this form is to gather information for the Wisconsin Works (W-2) program At Risk Pregnancy (ARP) placement. The W-2 ARP placement provides payment and services to eligible pregnant women who are unable to work due to an at risk pregnancy. **This placement requires:**

- **The pregnant woman to not have custody of any dependent (minor) children in their home;**
- **The pregnant woman to be unmarried; and**
- **The pregnant woman to provide medical verification of:**
 - **Third trimester of pregnancy (based on the estimated delivery date);**
 - **The pregnancy is a high risk pregnancy; and**
 - **The high risk pregnancy results in the woman not being able to work.**

The W-2 ARP placement requires this form (or all of the same items on the physician's letterhead) to be completed by the patient's physician based on the physician's medical examination of the patient within four months from the expected delivery date.

Note: The information you provide on this form will not affect billing or reimbursement from Medicaid.

If you have any questions, please contact the W-2 agency at:

[Insert W-2 agency's phone # and fax #]

Thank you!

Patient's Full Name:		Patient's Date of Birth: / /
What is the patient's estimated delivery date? / /		
Does this patient have a high risk pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is the cause of the patient's pregnancy being a high risk pregnancy?		
If yes, does the high risk pregnancy cause the patient to be unable to work (based on the physician's best determination)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the start date (if prior to the signature date on this form) for the patient being unable to work due to the high risk pregnancy? / /		
Any other comments (by the patient's physician):		
Physician's specialty area: (check all that apply) <input type="checkbox"/> General Medicine <input type="checkbox"/> Family Medicine <input type="checkbox"/> Obstetrics <input type="checkbox"/> Other, please specify:		
National Provider Identifier (NPI):		
Physician's Signature:	Signature Date: / /	Physician's Name (legibly printed):
Physician's e-mail address:		
Physician's phone #:	Physician's fax #:	
Physician's Office Address:	City:	State/Zip:

Please return the completed form to:

[Insert W-2 agency's name, street address, city, state, zip]