WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10075 (12/09)

MAS

WISCONSIN WELL WOMAN MEDICAID DETERMINATION

Use this form to enroll or renew enrollment in the Wisconsin Well Woman Medicaid plan. If this is an initial request to enroll in Wisconsin Well Woman Medicaid, the individual must already be enrolled in one of the programs listed below. Please check the program in which she is currently enrolled. If this is a renewal for Well Woman Medicaid, please check 'Renewal'.

☐ Family Planning Waiver Plan
☐ BadgerCare Plus Benchmark
☐ BadgerCare Plus Core Plan
☐ Wisconsin Well Woman Program (see below)
☐ Renewal

If enrolled in the Wisconsin Well Woman Program, a copy of the Wisconsin Well Woman Health Screening Program form (F-44818) must be attached to this form.

Personally identifiable information and Social Security Numbers are used only for the direct administration of the Medicaid program. Any person who wants Wisconsin Medicaid, but does not provide his/her SSN or apply for one will not be able to get benefits, pursuant to Wisconsin Statutes § 49.82(2).

Part A – **Applicant/Member Information** – To enroll or renew enrollment, the applicant/member must complete this section in full. Forms with missing information (including unsigned forms) will be returned which may cause enrollment delays. To enroll, an applicant must be a U.S. citizen or qualifying immigrant, a Wisconsin resident **and** under age 65.

PART A – Applicant/Member Information

Name – (Last, First, MI)	Maiden Name	Social Security Number	Member ID Number
Street Address	City	State / Zip	Birthdate (mm/dd/yy)
SIGNATURE – Applicant/Member	Telephone Number ( )	Date Signed (mm/dd/yy)	U.S. Citizen? ☐ Yes ☐ No

Do you have private major medical insurance? ☐ Yes ☐ No If yes, complete the following

Company ____________________ Policy Number ____________________ Phone ______________

Part B – **Diagnosing Provider** - This section must be completed by the Wisconsin Well Woman Program/BadgerCare Plus diagnosing provider attesting to the screening, diagnosis and treatment recommendation for the applicant above. Incomplete or illegible information may cause the form to be returned or delay enrollment.

Recertifying Provider — This section must be completed by the Wisconsin Well Woman Program or BadgerCare Plus recertifying provider at renewal. Complete Part B, sign and date the form attesting to the need for ongoing treatment for the member listed.

PART B – Diagnosing or Recertifying Provider - Must be NP, MD or DO

Name (Last, First, MI)

Street Address - Diagnosing Provider	City	State	Zip

Date of Screen	Date of Diagnosis	Check diagnosis for this applicant ☐ Breast cancer ☐ Cervical cancer ☐ Pre-cancerous condition of the cervix

TEMPORARY ELIGIBILITY/ENROLLMENT (available to Wisconsin Well Woman Program applicants only) — To be temporarily enrolled in the Well Woman Medicaid plan, the applicant must be a U.S. citizen and enrolled in the Wisconsin Well Woman Program. If she is not a U.S. citizen, she may still be eligible to enroll in Well Woman Medicaid, however, she will need to apply at a state or local agency (see Provider Handbook)

Temporary Enrollment Begin Date (date of diagnosis)	Temporary Enrollment End Date (last day of the month following the month of diagnosis.)

SIGNATURE / Credentials – Diagnosing/Recertifying Provider	Date Signed (mm/dd/yy)	Telephone Number ( )

Certifying Agency Action

WI. Stats. § 49.473, 49.45 (4)

White - IM Yellow - Provider Pink - Local Coordinating Agency for- WWWP Clients Blue – Applicant

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IF YOU RECEIVE WISCONSIN WELL WOMAN MEDICAID, present your ForwardHealth card each time you go to your Wisconsin Well Woman Medicaid providers such as physicians, hospitals, druggist, dentist, etc. There are no copayments for women enrolled in Wisconsin Well Woman Medicaid. If you have questions about your enrollment, contact your certifying agency. If you have questions about your covered benefits you should call Member Services at 1-800-362-3002.

IF YOU RECEIVE BENEFITS OR SERVICES, you must follow these rules:
- DO NOT give false information or hide information to get or continue to get benefits.
- DO NOT trade or sell your ForwardHealth card.
- DO NOT alter your ForwardHealth card to get benefits you are not entitled to receive.
- DO NOT use someone else's ForwardHealth card.

REPORTING CHANGES
You must report to the agency* **within 10 days:**
- If you move out of state,
- If you turn 65 years of age,
- If you get health insurance that pays for your cancer treatment,
- If you become eligible for Medicare (Parts A or B)
- If you change your address in Wisconsin.

*See your Notice of Decision for agency contact information.

OTHER MEDICAL COVERAGE
As a condition of enrollment, you must report to the agency any third party insurance or award that may be liable to pay for your medical care. You must cooperate by reporting this information. If you have Medicare Parts A, or B, or any private health insurance that covers your cancer treatment, you can no longer get Wisconsin Well Woman Medicaid.

OVERPAYMENTS
You must pay back Medicaid any benefits you get by mistake under certain situations.

YOU HAVE THE RIGHT TO A WRITTEN NOTICE from the agency* before any action is taken to stop or reduce your Wisconsin Well Woman Medicaid benefits. For most actions, a notice will be mailed to you at least 10 days before the action is taken.

*See your Notice of Decision for agency contact information.

YOU MAY REQUEST A FAIR HEARING if you disagree with any agency's action including your Wisconsin Well Woman Medicaid. You may request a fair hearing in writing or in person with your agency. You may also request a fair hearing by writing to the Department of Administration, Division of Hearings and Appeals, PO Box 7875, Madison, WI 53707-7875 or by calling 1-608-266-3096. Your request must be received within 45 days of the action's effective date.

In most cases, if your fair hearing request is received by the Division of Hearings and Appeals prior to the action's effective date, your benefits will not stop or be reduced. The benefits will continue at least until the decision on your appeal is made. During this time, if another unrelated change occurs, your benefits may change. If another change occurs, you will receive a new notice. If you are not satisfied with the fair hearing decision, you may appeal and request a second fair hearing. If the fair hearing decision ends or reduces your benefits, you may have to repay any benefits you receive while your appeal was pending. You may ask not to receive continued benefits.

YOU MAY REPRESENT YOURSELF OR BE REPRESENTED at the hearing by an attorney, friend or anyone else you choose. We cannot pay for your attorney. However, free legal services may be available to you if you qualify. If you fail to appear, or your representative fails to appear at the hearing without good cause, your appeal is considered abandoned and will be dismissed.

NON-DISCRIMINATION STATEMENT
The Department of Health Services is an equal opportunity employer and service provider. All people applying for or who get benefits are protected against discrimination based on race, color, national origin, disability, age, sex, or religion. State and federal laws require all Well Woman Medicaid benefits to be provided on a nondiscriminatory basis. To file a complaint of discrimination, contact either the:

Wisconsin Department of Health Services
Affirmative Action/Civil Rights Compliance Office
1 W. Wilson, Room 555
Madison, WI 53707-7850

Telephone: (608) 266-9372 (voice)
(888) 701-1251 (TTY)
(608) 267-2147 (fax)

OR

U.S. Department of Health and Human Services
Office for Civil Rights – Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601

Telephone: (312) 886-5077 (voice) or
(312) 353-5693 (TTY)

For civil rights questions call (608) 266-9372 or 1-888-701-1251 (TTY).