WISCONSIN WELL WOMAN PROGRAM

BREAST CANCER DIAGNOSTIC AND FOLLOW UP REPORT (DRF) INSTRUCTIONS

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

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

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 service.

The use of this form is mandatory when submitting claims for Wisconsin Well Woman Program services.

For reimbursement, mail this completed form with the completed claim to the following address:

Wisconsin Well Woman Program
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

SECTION I – BILLING PROVIDER INFORMATION

Element 1: Provider ID
Required. ForwardHealth providers are required to enter a National Provider Identifier (NPI).

Element 2: Name – Billing Provider
Required. Enter the billing provider's name.

Element 3: Taxonomy Code
Required. Enter the 10-digit taxonomy code on file with ForwardHealth.

Element 4: Practice Location Zip+4 Code
Required. Enter the complete zip+4 code associated with the practice service location on file with ForwardHealth.

SECTION II – CLIENT PERSONAL INFORMATION

Element 5: Last Name – Client
Required. Enter the client's last name.

Element 6: First Name – Client
Required. Enter the client's first name.

Element 7: Middle Initial – Client
Enter the client's middle initial.

Element 8: Previous Last Name – Client
Enter the client's previous last name, if applicable.

Element 9: Client ID Number
Required. Enter the client ID.

Element 10: Date of Birth
Required. Enter the client's date of birth in MM/DD/CCYY format.

SECTION III – BREAST DIAGNOSTIC PROCEDURES

Additional Mammographic Views
Element 11: Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a mammogram.

Element 12: Name – Rendering Provider
Enter the rendering provider's name.

Element 13: Result
Required if this procedure is performed. Check one box only to reflect the results of the additional mammographic views. If a shaded result is selected, follow up is required.

Breast Consultation
Element 14: Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a breast consultation.

Element 15: Name – Rendering Provider
Enter the rendering provider's name.

Element 16: Result / Recommendation
Required if this procedure is performed. Check one box only to reflect the results of the breast consultation. If a shaded result is selected, follow up is required.

Ultrasound
Element 17: Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received an ultrasound.

Element 18: Name – Rendering Provider
Enter the rendering provider's name.

Element 19: Result
Required if this procedure is performed. Check one box only to reflect the results of the ultrasound. If a shaded result is selected, follow up is required.

Film Comparison
Element 20: Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a film comparison.

Element 21: Name – Rendering Provider
Enter the rendering provider's name.

Element 22: Result
Required if this procedure is performed. Check one box only to reflect the results of the film comparison. If a shaded result is selected, follow up is required.

MRI
Element 23: Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received an MRI.

Element 24: Name – Rendering Provider
Enter the rendering provider's name.

Element 25: Result
Required if this procedure is performed. Check one box only to reflect the results of the MRI. If a shaded result is selected, follow up is required.

Fine Needle Aspiration
Element 26: Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a fine needle aspiration.

Element 27: Name – Rendering Provider
Enter the rendering provider's name.

Element 28: Result
Required if this procedure is performed. Check one box only to reflect the results of the fine needle aspiration. If a shaded result is selected, follow up is required.

Biopsy

Element 29: Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a biopsy.

Element 30: Name – Rendering Provider
Enter the rendering provider's name.

Element 31: Biopsy Associated Imaging
Select "mammogram," "ultrasound," or both, if applicable.

Element 32: Result
Required if this procedure is performed. Check one box only to reflect the results of the biopsy.

SECTION IV – RECOMMENDATIONS AND DIAGNOSIS

Element 33: Notes
Enter notes, if applicable.

Element 34: Recommendation
This field is required if elements from Additional Mammographic Views, Breast Consultation, Ultrasound, Film Comparison, MRI, Fine Needle Aspiration, or Biopsy are completed. Check all applicable boxes. If checking "Follow Routine Screening Schedule" or "Short Term Follow-up," include the appropriate number of months.

Element 35: Status of Final Diagnosis
Required. Check one box only to reflect the status of the client's final diagnosis.

Element 36: Final Diagnosis
This field is required if "complete" is checked in Element 35. Check one box only to reflect the final diagnosis and enter the date (in MM/DD/CCYY format).

Element 37: Tumor Stage and Tumor Size
This field is required if the Final Diagnosis is Invasive Breast Cancer. Check one box to reflect the stage of the client's tumor. Enter the size of the client's tumor in centimeters.

Element 38: Treatment Status
This field is required if the Final Diagnosis is Ductal Carcinoma in Situ (DCIS) or Invasive Breast Cancer. Check one box only to reflect the client's treatment status.

Element 39: Treatment Date
This field is required if the Final Diagnosis is Ductal Carcinoma in Situ (DCIS) or Invasive Breast Cancer. Enter the treatment date (in MM/DD/CCYY format) as applicable.