**DEPARTMENT OF HEALTH SERVICES**
Division of Public Health
F-44729I (11/2023)

**STATE OF WISCONSIN**
Wis. Stat. § 255.075

**WISCONSIN WELL WOMAN PROGRAM**

# CERVICAL 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 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 – CERVICAL DIAGNOSTIC PROCEDURES

**Endocervical Curettage**
**Element 11: Date Performed**
Required if these procedures are performed. Enter the date (in MM/DD/CCYY format) on which the client received an endocervical curettage.

**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 result of the client's endocervical curettage. If a shaded result is selected, follow up is required.

**Colposcopy Without Biopsy**
**Element 14: Date Performed**
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a colposcopy without biopsy.

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

**Element 16: Result**
Required if this procedure is performed. Check one box only to reflect the result of the client's colposcopy without biopsy. If a shaded result is selected, follow up is required.

**Loop Electrosurgical Excision Procedure (LEEP)**
**Element 17: Date Performed**
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a loop electrosurgical excision procedure (LEEP).

**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 result of the client's LEEP. If a shaded result is selected, follow up is required.

**Colposcopy With Biopsy**
**Element 20: Date Performed**
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a colposcopy with biopsy.

**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 result of the client's colposcopy with biopsy. If a shaded result is selected, follow up is required.

**Cold Knife Cone**
**Element 23: Date Performed**
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a cold knife cone.

**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 result of the client's cold knife cone. If a shaded result is selected, follow up is required.

**Endometrial Biopsy**
**Element 26: Date Performed**
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received an endometrial biopsy.

**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 result of the client's endometrial biopsy. If a shaded result is selected, follow up is required.

## SECTION IV – RECOMMENDATIONS AND DIAGNOSIS

**Element 29: Notes**
Enter notes, if applicable.

**Element 30: Recommendation**
This field is required if elements under Endocervical Curettage, Colposcopy Without Biopsy, Loop Electrosurgical Excision Procedure (LEEP), Colposcopy With Biopsy, Cold Knife Cone, and/or Endometrial Biopsy are completed. Check all applicable recommendations. If checking “Follow Routine Screening Schedule” or “Short Term Follow-up,” include the appropriate number of months.

**Element 31: Status of Final Diagnosis**
Required. Check one box only to reflect the status of the client’s final diagnosis.

**Element 32: Final Diagnosis**
If “Complete” is selected in Element 31, this element is required. Check one box only to reflect the final diagnosis. Enter date in MM/DD/CCYY format. If checking “Other,” enter the client’s final diagnosis in text box.

**Element 33: Tumor Stage**
This field is required if the Final Diagnosis is Invasive Cervical Cancer or Adenocarcinoma of the Cervix. Check one box to reflect the client’s tumor stage.

**Element 34: Treatment Status**
This field is required if the Final Diagnosis is CIN 2/Moderate Dysplasia, CIN 3/Severe Dysplasia/CIS, HSIL (Biopsy Diagnosis), Invasive Cervical Cancer, or Adenocarcinoma of the Cervix. Check one box only to reflect the client’s treatment status.

**Element 35: Treatment Date**
This field is required if the Final Diagnosis is CIN 2/Moderate Dysplasia, CIN 3/Severe Dysplasia/CIS, HSIL (Biopsy Diagnosis), Invasive Cervical Cancer, or Adenocarcinoma of the Cervix. Enter the treatment date (in MM/DD/CCYY format) as applicable.