WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02766 (06/2023)

RSUD

RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT FOR BADGERCARE PLUS AND MEDICAID MEMBERS

INSTRUCTIONS: Residential substance use disorder (SUD) treatment is covered by both BadgerCare Plus and Medicaid in Wisconsin. Residential SUD treatment facilities should complete this form to inform income maintenance (IM) and tribal agencies that a BadgerCare Plus or Medicaid member has been:

- Admitted to a residential SUD treatment facility to get treatment.
- Discharged from a residential SUD treatment facility after getting treatment.
- Transferred to a different inpatient residential SUD treatment facility to continue getting treatment.

Complete and send this form only for members who are shown in the ForwardHealth Portal as enrolled in the following benefit plans:*

- BC+ Standard Plan
- Medicaid
- Medicaid Waiver
- Medicaid Purchase Plan
- Medicaid Purchase Plan Waiver

*The benefit plan names are listed as they are displayed in the ForwardHealth Portal and may be different than the current program names used in member letters.

Note: This form does not need to be completed for members of other health care programs, such as SSI Medicaid or Foster Care Medicaid.

An application will need to be submitted for anyone applying for BadgerCare Plus, Medicaid, or FoodShare. This form should be completed and sent at the same time as any benefit application.

Mail or fax this completed form within 10 days to the Milwaukee Document Processing Unit (MDPU) for individuals who lived in Milwaukee County before entering treatment or to the Central Document Processing Unit (CDPU) for individuals who lived in any other county before entering treatment.

MDPU
6055 N. 64th St.
Milwaukee, WI 53218
Fax: 888-409-1979

CPDU
PO Box 5234
Janesville, WI 53547-5234
Fax: 855-293-1822

If you have questions about this form, call ForwardHealth Provider Services at 800-947-9627.

RSUD

SECTION 1 – RESIDENTIAL SUD TREATMENT FACILITY INFORMATION

Name – Staff Member (Last, First, MI)	Job Title
Work Phone Number	Email Address – Staff Member

Facility Name

Facility Street Address

City	State	Zip Code

Is the facility certified to provide the Medicaid residential SUD treatment benefit?

☐ Yes ☐ No

Note: If you checked Yes, fill out the facility type below. If you checked No, the facility type is not required, skip to Section 2.

Is the facility enrolled as an institution for mental diseases (IMD)?

☐ Yes ☐ No

If No, what is the facility type?

☐ Community-Based Residential Facility ☐ Hospital

SECTION 2 – MEMBER OR APPLICANT INFORMATION

Name – Applicant or Member (Last, First, MI)	Date of Birth (MM/DD/YYYY)

Please provide one of the following identifications for the member or applicant.

☐ Member ID – Member

☐ CARES Case Number – Member

☐ ACCESS Tracking Number – Applicant

If you are **not** able to provide any of the above identifiers for the member or applicant, please provide the member or applicant's Social Security number.*

☐ Social Security Number – Member or Applicant

*The member or applicant's Social Security number is only required if the member or applicant is unable to provide a member ID, CARES case number or ACCESS tracking number. In that case, the Social Security number is required to match the member or applicant to their existing benefit information.

Is the individual getting FoodShare benefits?

☐ Yes ☐ No ☐ Unknown

RSUD

Check the appropriate box below to provide more information about the member or applicant's residential SUD treatment facility status and enter the date of the admission, discharge, or transfer.

☐ **Admission:** Check this box if an individual has been admitted to the facility for inpatient residential SUD treatment. This includes individuals who have transferred to your facility from another treatment facility.

☐ **Discharge:** Check this check box if an individual has been discharged from inpatient residential SUD treatment. This includes individuals who are continuing treatment on an outpatient basis only.

☐ **Transfer:** Check this check box if an individual has transferred out of your facility and into another facility for continued inpatient residential SUD treatment.

Name of new facility (if known): _____

Date of admission, discharge, or transfer (MM/DD/YYYY): _____

Are there any dependents residing at the residential SUD treatment facility with the member or applicant?

☐ Yes ☐ No

If yes, please provide the name and date of birth of the dependent(s) below. Please attach an additional page if more dependents need to be listed.

Name – Dependent (Last, First, MI)	Date of Birth (MM/DD/YYYY)
Name – Dependent (Last, First, MI)	Date of Birth (MM/DD/YYYY)
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Name – Dependent (Last, First, MI)	Date of Birth (MM/DD/YYYY)

SECTION 3 – SIGNATURE AND DATE

SIGNATURE – Staff Member	Date Signed