# DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN

Division of Medicaid Services Wis. Stat. § 49.45

F-03203 (09/2024)

## WISCONSIN MEDICAID

**DISENROLLMENT OF ADULT LONG-TERM CARE (LTC) WAIVER PROGRAMS AND SERVICES**

**INSTRUCTIONS:** Type or print clearly. All providers must fill out Sections I and II. Complete Section III if this form is being submitted by a third party, such as a managed care organization (MCO) or IRIS (Include, Respect, I Self-Direct) fiscal employer agency (FEA) on behalf of a provider.

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| SECTION I – PROVIDER INFORMATION | | | |
| 1. Name – Provider (Organization or Individual) | | | |
| 2. Provider Medicaid ID | | | |
| 3. Name – Person Completing the Form | | | |
| SECTION II – ADULT LTC WAIVER SERVICES OR PROGRAMS FOR DISENROLLMENT | | | |
| 4. Program(s) to Remove   IRIS   Family Care   Family Care Partnership   PACE (Program of All-Inclusive Care for the Elderly) | | | |
| 5. Service(s) to Remove | | | |
| 6. Effective Date of Requested Removal | |  | |
| 7. **SIGNATURE** – Provider | | 8. Date Signed by Provider (Required even if completed by the Third-Party Delegate) | |
| SECTION III – THIRD-PARTY DELEGATE INFORMATION | | | |
| 9. Name – Third-Party Agency (MCO or FEA) | | | |
| 10. Name – Third-Party Delegate | | | |
| 11. Phone Number – Third-Party Delegate | 12. Email Address – Third-Party Delegate | | |
| 13. **SIGNATURE** – Third-Party Delegate | | | 14. Date Signed by Third-Party Delegate |