DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services
F-10075 (03/2024)

WISCONSIN WELL WOMAN MEDICAID APPLICATION AND RENEWAL

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 they are currently enrolled.

☐ Family Planning Only Services or BadgerCare Plus ☐ Wisconsin Well Woman Program (see below)

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.

If this is a renewal for Well Woman Medicaid, please check Renewal. ☐ Renewal

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 their Social Security number or apply for one will not be able to get benefits, pursuant to Wis. Stat. § 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 – Applicant/Member (Last, First, MI)	Maiden Name	Social Security Number		Member ID Number
Street Address	City	State	ZIP Code	Date of Birth

SIGNATURE – Applicant/Member	Date Signed	Phone Number	U.S. Citizen? ☐ Yes ☐ No

If **not** a U.S. citizen, provide the following:

Immigration Document Type	Document ID Number

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

Company	Policy Number	Phone Number

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, and sign and date the form.

PART B – DIAGNOSING OR RECERTIFYING PROVIDER: MUST BE NURSE PRACTITIONER (NP), CLINICAL NURSE SPECIALIST (CNS), CERTIFIED NURSE-MIDWIFE (CNM), PHYSICIAN ASSISTANT (PA), MEDICAL DOCTOR (MD), OR DOCTOR OF OSTEOPATHIC MEDICINE (DO)

Name (Last, First, MI)	Credentials		
Street Address – Diagnosing Provider	City	State	ZIP Code

Date of Screen	Date of Diagnosis	Check diagnosis for this applicant
		☐ Breast cancer ☐ Cervical cancer ☐ Precancerous condition of the breast or cervix

☐ I attest that the applicant **needs** ongoing treatment and/or surveillance monitoring for the diagnosis above, or
☐ I attest that the applicant **no longer needs** ongoing treatment and/or surveillance monitoring

SIGNATURE/Credentials – Diagnosing/Recertifying Provider	Date Signed	Phone Number

Send completed application or renewal to EM CAPO by email dhsemcapo@dhs.wisconsin.gov, fax 608-267-3381, or mail WI DHS – EM CAPO, 1 W. Wilson Street, PO Box 309, Madison, WI 53701.

PART C – TEMPORARY ENROLLMENT/PRESUMPTIVE ELIGIBILITY: This section must be completed by the diagnosing provider. To be temporarily enrolled in the Wisconsin Well Woman Medicaid plan, the applicant **must** be a U.S. citizen and enrolled in the Wisconsin Well Woman Program. Fax applications for temporary enrollment/presumptive eligibility to 608-221-8815.

Begin Date (Date of Diagnosis)	End Date (Last Day of Month Following Month of Diagnosis)

WI. Stat. §§ 49.473, 49.45 (4).

RESET FORM

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

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, pharmacies, or dentists. There are no copayments for people enrolled in Wisconsin Well Woman Medicaid. If you have questions about your enrollment, contact the Wisconsin Well Woman Medicaid program. If you have questions about your covered benefits, contact Member Services at 800-362-3002.

RESPONSIBILITIES
You must provide truthful and complete information. If you receive Wisconsin Well Woman Medicaid, you must not trade, sell, or alter your ForwardHealth card, or use someone else's card. You must report to the agency any third-party insurance or award that may be liable to pay for your medical care.

REPORTING CHANGES
If you are enrolled in Wisconsin Well Woman Medicaid, you must report to the agency **within 10 days** if you:
- Turn 65 years of age.
- Move out of state.
- Have a change in address.
- No longer need treatment for breast or cervical cancer.
- Get health insurance that pays for your cancer treatment.
- Get Medicare Part A, Part B, or both.

Report changes to the agency any of the following ways:
- Phone: 608-266-1720 or 877-246-2276
- Email: dhsemcapo@dhswisconsin.gov
- Fax: 608-267-3381
- Mail: WI DHS – EM CAPO, 1 W. Wilson Street, PO Box 309, Madison, WI 53701

RIGHTS
State and federal laws guarantee rights for applicants and members, including the right to:
- Be treated with respect by state employees.
- Confidentiality of all information given to agencies to determine enrollment. (This does not prohibit the use of such information for program administration.)
- Have access to agency records and files relating to your case, except information obtained by the local agency under a promise of confidentiality.
- Remain enrolled in Wisconsin Well Woman Medicaid even if temporarily absent from the state if you remain a Wisconsin resident.
- A speedy determination of enrollment status and prior notice of proposed changes in such status.
- Request reasonable accommodation to participate in the program for a disability-related reason, or the right to request interpreters or translators to participate in the program.
- Appeal any action taken concerning your application or benefits that you do not agree with by requesting a fair hearing.

FAIR HEARING
You have the right to a fair hearing if you think there has been a wrong decision about your application or benefits. You can get the Request for Fair Hearing form at www.dhs.wisconsin.gov/forwardhealth/resources.htm. You can send the form or a letter asking for a hearing to the Division of Hearings and Appeals, PO Box 7875, Madison, WI 53707-7875, or fax it to 608-264-9885. The Division of Hearings and Appeals must get your request no later than 45 days from the date of the action. Refer to the ForwardHealth Enrollment and Benefits handbook or your Letter of Enrollment to learn more about the fair hearing process. You will get your handbook soon after you apply. You can also find the handbook at www.dhs.wisconsin.gov/library/p-00079.htm.

HHS NONDISCRIMINATION NOTICE
The Wisconsin Department of Health Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity. The Department of Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Department of Health Services:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - o Qualified sign language interpreters
    - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - o Qualified interpreters
    - o Information written in other languages

If you need these services, contact the Department of Health Services civil rights coordinator (844-201-6870).

If you believe that the Department of Health Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity, you can file a grievance with: Department of Health Services, Attn: Civil Rights Coordinator, 1 West Wilson Street, Room 651, PO Box 7850, Madison, WI 53707-7850, 608-267-4955, TTY: 711, Fax: 608-267-1434, dhscrc@dhs.wisconsin.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Department of Health Services civil rights coordinator is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.