

**WISCONSIN MEDICAID
DEGREE ADDENDUM**

TO: ForwardHealth
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

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

Personally identifiable information about providers or other entities is used for purposes directly related to program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for services.

The use of this form is mandatory.

I hereby certify that _____ received a Master's degree in nursing from this institution on
(Name — Provider)

_____ and that the course of study completed prepared this person for a role as a registered nurse in
(Date)

advanced clinical nursing practice. The curriculum completed is accredited by _____.
(Name — College / University)

SIGNATURE

Date Signed

Title

Name — College / University

Address 1

Address 2



F-11260