DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44723I (11/2023)

STATE OF WISCONSIN
Wis. Stat. § 255.075

WISCONSIN WELL WOMAN PROGRAM (WWWP)

BREAST AND CERVICAL CANCER SCREENING ACTIVITY REPORT (ARF) 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 or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the service.

The use of this form is mandatory when submitting claims for Wisconsin Well Woman Program services.

For reimbursement, mail this 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 billing 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
Not required. Enter the client's middle initial.

Element 8: Previous Last Name – Client
Not required. Enter the client's previous last name, if applicable.

Element 9: Client ID Number
Required. Enter the client ID.

Element 10: Date of Birth – Client
Required. Enter the client's date of birth in MM/DD/CCYY format.

SECTION III – BREAST AND CERVICAL SCREENING

Breast Screening History
Element 11: Previous Mammogram?
Check "Yes," "No," or "Unknown" to indicate whether or not the client has had a previous mammogram.

Element 12: Date of Previous Mammogram
If known, provide the date (in MM/DD/CCYY format) on which the client received their last mammogram.

Element 13: Client Currently Reporting Breast Symptoms?
Check "Yes," "No," or "Unknown" to indicate whether or not the client is currently reporting breast symptoms.

Office Visit Without CBE Only
Element 14: Date of Office Visit
Required if this procedure is performed. Enter the date of the office visit in MM/DD/CCYY format.

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

Element 16: Result
Required if this procedure is performed. Check the relevant box to indicate whether or not follow up is needed. Check only one box.

Clinical Breast Exam (CBE)
Element 17: Purpose of CBE
Required if this procedure is performed. Check whether the client's CBE is a screening or repeat exam. Check only one box.

Element 18: Date of CBE
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received the CBE.

Element 19: Name – Rendering Provider
Enter the rendering provider's name.

Element 20: Result
Required if this procedure is performed. Check one box to reflect the results of the CBE. If a shaded result is selected, follow up is required.

Mammogram
Element 21: Indication for Initial Mammogram
Required if this procedure is performed. Check the appropriate box to indicate the reason for the initial mammogram. Check only one box.

Element 22: Date of Breast Diagnostic Referral
Enter the date (in MM/DD/CCYY format) on which the client received the breast diagnostic referral.

Element 23: High Risk for Breast Cancer
Required if Initial Mammogram is performed. Check the appropriate box to indicate whether or not the client is at high risk for breast cancer or whether the risk is unknown.

Element 24: Date of Initial Mammogram
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received an initial mammogram.

Element 25: Name – Rendering Provider
Enter the rendering provider's name.

Element 26: Mammogram Result
Required if this procedure is performed. Check one box to reflect the results of the mammogram. If a shaded result is selected, follow up is required.

Breast Follow-Up Recommendations
Element 27: Recommendation(s)
This element is required when Office Visit Without CBE Only, CBE, or Mammogram sections are completed. Check all applicable boxes. If checking "Follow Routine Screening" or "Short Term Follow-up," include the appropriate number of months.

Cervical Screening History
Element 28: Prior Pap Test?
Check the appropriate box to indicate whether or not the client has had a prior pap test.

Element 29: Date of Last Pap Test
If Element 28 is marked "Yes," enter the date (in MM/DD/CCYY format) on which the client received their last pap test.

Pelvic Exam

Element 30: Date of Pelvic Exam
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a pelvic exam.

Element 31: Name – Rendering Provider
Enter the rendering provider's name.

Element 32: Result
Required if this procedure is performed. Check one box to reflect the results of the pelvic exam. If a shaded result is selected, follow up is required.

Pap Test

Element 33: Indication for Pap Test
Required if this procedure is performed. Check the appropriate box to indicate the reason for the pap test. Check only one box.

Element 34: Date of Cervical Diagnostic Referral
Enter the date (in MM/DD/CCYY format) on which the client received a cervical diagnostic referral.

Element 35: Type of Pap Test
Required if this procedure is performed. Check one box to select whether the pap test is liquid based or conventional.

Element 36: High Risk for Cervical Cancer
Required if the Pap Test is performed. Check the appropriate box to indicate whether or not the client is at high risk for cervical cancer or whether the risk is unknown.

Element 37: Date of Pap Test
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a pap test.

Element 38: Name – Rendering Provider
Enter the rendering provider's name.

Element 39: Adequacy of Pap Test Specimen
Required if this procedure is performed. Check one box to indicate whether the pap test specimen is satisfactory or unsatisfactory.

Element 40: Pap Result
Required if this procedure is performed. Check one box only to indicate the results of the pap test. If a shaded result is selected, follow up is required.

HPV Test

Element 41: Indication for HPV Test
Required if this procedure is performed. Check the appropriate box to indicate why an HPV test was indicated. Check only one box.

Element 42: Date of HPV Test
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received an HPV test.

Element 43: Result
Required if this procedure is performed. Check one box only to indicate the result of the client's HPV test. If a shaded result is selected, follow up is required.

Cervical Follow-Up Recommendations

Element 44: Recommendation(s)
This element is required when the Pelvic Exam, Pap Test, or HPV Test sections are completed. Check all applicable boxes. If checking "Follow Routine Screening" and "Short Term Follow-up," include the appropriate number of months.

Element 45: Notes
Enter any additional recommendations in the space provided.