

APPENDIX A: FORMS

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WCLPPP Reporting Forms – Nursing Case Management Report

DEPARTMENT OF HEALTH SERVICES

Division of Public Health
F-44771A (Rev 11/06)

STATE OF WISCONSIN

ss. 254.15, Wis. Stats
Phone (608) 266-5817
FAX (608) 267-0402

NURSING CASE MANAGEMENT REPORT

Case Management Of Children with Elevated Blood Lead Levels*

*Elevated Blood Lead Level (EBLL) = 1 venous Blood Lead Level (BLL) ≥ 20 mcg/dL **OR**
2 venous BLLs of ≥ 15 mcg/dL drawn at least 90 days apart.

Completion of this form is mandatory for agencies contracting with the Division of Public Health for program funding. Personal identifiable information collected on this form will be used to document a completed home visit, assess the developmental status and determine the services needed. Data will be used in the aggregate to assist research and project future service needs. Nursing case management should follow the Case Management Protocol in the Wisconsin Childhood Lead Poisoning Prevention Program Handbook.

CHILD INFORMATION

Name of Child	Last	First	MI	Date of Birth (mm/dd/yy)
Current Street Address	Apt. No.	City	County	Zip Code
Race	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> White <input type="checkbox"/> Other (specify):			
Ethnicity	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Legal Guardian Name	Last	First		

DEVELOPMENTAL ASSESSMENT

Name of Case Manager	Telephone No. (include area code)
Date of Home Visit: (mm/dd/yy) (must be completed before form is submitted)	
Date of Developmental Screening Test: (mm/dd/yy)	
Results of Developmental Screening Test were:	<input type="checkbox"/> Within Normal Limits Delays noted in: <input type="checkbox"/> Language <input type="checkbox"/> Gross Motor Skills <input type="checkbox"/> Fine Motor Skills <input type="checkbox"/> Personal-Social <input type="checkbox"/> Other (specify):
If 2 or more delays are identified, standard of practice followed was:	<input type="checkbox"/> Repeat test scheduled in 2-4 weeks or <input type="checkbox"/> Referral for developmental services. Give name of provider:
The child or family is enrolled in the following programs:	<input type="checkbox"/> Head Start <input type="checkbox"/> Birth to 3/Early Intervention <input type="checkbox"/> Early Childhood <input type="checkbox"/> Parenting <input type="checkbox"/> 4-Year Kindergarten <input type="checkbox"/> Children with Special Health Care Needs (Regional CSHCN Center) <input type="checkbox"/> Other (describe):
The child or family has been referred to the following programs:	<input type="checkbox"/> Head Start <input type="checkbox"/> Birth to 3/Early Intervention <input type="checkbox"/> Early Childhood <input type="checkbox"/> Parenting <input type="checkbox"/> 4-Year Kindergarten <input type="checkbox"/> Children with Special Health Care Needs (Regional CSHCN Center) <input type="checkbox"/> Refuses referral <input type="checkbox"/> Other (describe):

Comments:

Send completed form to: **DEPARTMENT OF HEALTH AND FAMILY SERVICES**
Division of Public Health
Childhood Lead Poisoning Prevention Program
P. O. Box 2659, Room 145
Madison, WI 53701-2659

WCLPPP Reporting Forms – Nursing Case Closure Report

DEPARTMENT OF HEALTH SERVICES

Division of Public Health
F-44771B (Rev 11/06)

STATE OF WISCONSIN

ss. 254.15, Wis. Stats
Phone (608) 266-5817
FAX (608) 267-0402

NURSING CASE CLOSURE REPORT

Case Management Of Children with Elevated Blood Lead Levels*

*Elevated Blood Lead Level (EBLL) = 1 venous Blood Lead Level (BLL) ≥ 20 mcg/dL **OR**
2 venous BLLs of ≥ 15 mcg/dL drawn at least 90 days apart.

Completion of this form is mandatory for agencies contracting with the Division of Public Health for program funding. Data will be used in the aggregate to assist research and project future service needs. Nursing case management should follow the Case Management Protocol in the Wisconsin Childhood Lead Poisoning Prevention Program Handbook. The case manager should discuss provisions for appropriate long-term developmental follow-up with the primary health care provider and caregiver. Managing Elevated Blood Lead Levels Among Young Children, Centers for Disease Control & Prevention, 2002.

CHILD INFORMATION

Name of Child - Last	First	MI	Date of Birth (mm/dd/yy)
Current Street Address	Apt. No.	City	County Zip Code

Indicate how it was determined that the child is in a lead safe environment:	<input type="checkbox"/> Lead hazard remediation work complete, property met final visual clearance investigation, and dust wipe samples met clearance standards
	<input type="checkbox"/> Child moved to a new property identified as lead safe
	<input type="checkbox"/> The source of lead poisoning was not lead-based paint and the child is no longer exposed

CASE CLOSURE

Date Case Closed (mm/dd/yy)	Name of Case Manager	Telephone No. (include area code)
Reason for Closure:	<input type="checkbox"/> Minimum Closure Criteria Met: 2 BLLs < 15 mcg/dL at least 6 months apart and the child is in a lead-safe environment	
	<input type="checkbox"/> Moved, referral forwarded (if known, indicate new address below in comments)	
	<input type="checkbox"/> Unable to locate	
	<input type="checkbox"/> Family refuses further intervention	

FOLLOW-UP OF DEVELOPMENTAL SCREENING TEST

When the screening test indicates 2 or more delays, the standards of practice call for the test to be repeated in 2-4 weeks or a referral to a provider for a comprehensive developmental assessment. The results of these follow-up actions are:	<input type="checkbox"/> No follow-up needed; screening test within normal limits
	<input type="checkbox"/> The results of a second screening test were normal
	<input type="checkbox"/> The results of a second screening test or referral indicated delays in:
	<input type="checkbox"/> Language <input type="checkbox"/> Gross Motor Skills <input type="checkbox"/> Fine Motor Skills
	<input type="checkbox"/> Personal - Social <input type="checkbox"/> Other (specify):
	<input type="checkbox"/> Other (describe):

REFERRALS OR OTHER SERVICES

The child or family is enrolled in:	<input type="checkbox"/> Head Start <input type="checkbox"/> Birth to 3/Early Intervention <input type="checkbox"/> Early Childhood <input type="checkbox"/> Parenting
	<input type="checkbox"/> 4-Year Kindergarten <input type="checkbox"/> Children with Special Health Care Needs (Regional CSHCN Center)
	<input type="checkbox"/> Refused referral <input type="checkbox"/> Other (describe):

Comments:

Send completed form to:

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
Childhood Lead Poisoning Prevention Program
P. O. Box 2659, Room 145
Madison, WI 53701-2659

WCLPPP Reporting Forms – Property Investigation Report

DEPARTMENT OF HEALTH SERVICES

Division of Public Health
F-44771C (Rev. 11/06)

STATE OF WISCONSIN

ss. 254.15, 254.166, Wis. Stats.
Phone (608) 266-5817
FAX (608) 267-0402

PROPERTY INVESTIGATION REPORT

Case Management Of Children with Elevated Blood Lead Levels*

*Elevated Blood Lead Level (EBLL) = 1 venous Blood Lead Level (BLL) ≥ 20 mcg/dL **OR**
2 venous BLLs of ≥ 15 mcg/dL drawn at least 90 days apart.

Completion of this form is mandatory for agencies contracting with the Division of Public Health for program funding. Personal identifiable information collected on this form is used to describe the causes and conditions of lead poisoning and to monitor services provided. Data will be used in the aggregate to assist research and project future service needs.

CHILD INFORMATION

Name Last	First	MI	Date of birth (mm/dd/yy):
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PROPERTY INFORMATION

Street Address	Apt. No.	City	County	Zip Code
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Owner Name	Telephone No.
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Owner Street Address	City	State	Zip Code
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Year of Construction (Actual or Estimated):

Address is (check one): ☐ Residence when EBLL identified ☐ Current residence ☐ Supplemental Address
☐ Other (describe):

Type of residence (check one): ☐ Section 8 Housing ☐ Owner Occupied ☐ Private Rental ☐ Public Housing

Family received federally mandated "Protect Your Family from Lead in Your Home" pamphlet from landlord or previous owner when they first moved in or prior to purchase of home: ☐ Yes ☐ No

PROPERTY INVESTIGATION INFORMATION

Date Investigation Referred (mm/dd/yy)	Date of Investigation (mm/dd/yy)	Name of Certified Risk Assessor/Hazard Investigator:
--	----------------------------------	--

Main Cause(s) of Lead Based Paint Hazard(s) or Exposure (check all that apply)

<input type="checkbox"/> Deterioration	<input type="checkbox"/> Mouthing/chewing surfaces
<input type="checkbox"/> Remodeling	<input type="checkbox"/> Eating non-food items
<input type="checkbox"/> Repainting/scraping/sanding	<input type="checkbox"/> No Hazards present - property investigation closed
<input type="checkbox"/> Repair	<input type="checkbox"/> Other (describe):

Location of Potential Hazard(s) (check all that apply)

<u>Interior</u>		<u>Exterior</u>	
<input type="checkbox"/> Windows	<input type="checkbox"/> Floors/stairs	<input type="checkbox"/> Windows	<input type="checkbox"/> Siding
<input type="checkbox"/> Doors	<input type="checkbox"/> Walls	<input type="checkbox"/> Doors	<input type="checkbox"/> Ceilings
<input type="checkbox"/> Trim	<input type="checkbox"/> Ceilings	<input type="checkbox"/> Soil	<input type="checkbox"/> Porches
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	

Method of Collection for Environmental Samples

<u>Interior</u>		<u>Exterior</u>	
<input type="checkbox"/> XRF	<input type="checkbox"/> Paint chip	<input type="checkbox"/> XRF	<input type="checkbox"/> Paint chip
<input type="checkbox"/> Dust wipe		<input type="checkbox"/> Dust wipe	<input type="checkbox"/> Soil

Dates For Lead Hazard Reduction Completion (mm/dd/yy)

<u>Interior</u>	<u>Exterior</u>
Interim controls	Interim controls
Abatement	Abatement

Date Property Investigation Report Sent to: Owner: Tenant:

Local health department has notified the owner and posted a notice that the property is untenable, Wis. Stats. 704.07(4) and unsafe, dilapidated or unsanitary and therefore a human health hazard, Wis. Stats 254.59(3), or a presence of lead hazards Wis. Stats. 254.166 (2) ☐ Yes ☐ No

Other Lead Hazards or Sources Identified Based on Testing (check all that apply and describe): ☐ Folk remedies

☐ Mini-blinds ☐ Hobby ☐ Work related ☐ Pottery ☐ Water ☐ Other:

Description:

Send completed form to: DEPARTMENT OF HEALTH SERVICES
Division of Public Health
Childhood Lead Poisoning Prevention Program
P. O. Box 2659, Room 145
Madison, WI 53701-2659 Appendix A1.5

WCLPPP Reporting Forms – Property Investigation Closure Report

DEPARTMENT OF HEALTH SERVICES

Division of Public Health
F-44771D (Rev. 11/06)

STATE OF WISCONSIN

ss. 254.15, 254.166, Wis. Stats.
Phone (608) 266-5817
FAX (608) 267-0402

PROPERTY INVESTIGATION CLOSURE REPORT

Case Management Of Children with Elevated Blood Lead Levels*

*Elevated Blood Lead Level (EBLL) = 1 venous Blood Lead Level (BLL) \geq 20 mcg/dL **OR**
2 venous BLLs of \geq 15 mcg/dL drawn at least 90 days apart.

Completion of this form is mandatory for agencies contracting with the Division of Public Health for program funding. Personal identifiable information collected on this form is used to describe the causes and conditions of lead poisoning and to monitor services provided. Data will be used in the aggregate to assist research and project future service needs.

CHILD INFORMATION

Name of Child - Last	First	MI	Date of birth (mm/dd/yy)
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PROPERTY INFORMATION

Street Address	Apt. No.	City	County	Zip Code
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Name of Certified Risk Assessor/Hazard Investigator who conducted clearance:

Completion dates of lead hazard reduction work (mm/dd/yy):

☐ Interior interim controls:

☐ Exterior interim controls:

☐ Interior abatement:

☐ Exterior abatement:

Date Property Investigation Closed: (mm/dd/yy)

Reason Investigation Closed:

☐ Property passed final visual clearance investigation and dust wipe samples met clearance standards and local health department provided results to the owner and occupants.

☐ Property with only exterior lead-based paint hazards passed final visual clearance investigation

☐ Other identified lead hazards removed. Specify:

If lead hazard reduction work not completed, describe further action taken:

☐ Referred to local legal authorities

☐ Local health department has notified the owner and posted a notice that the property is untenantable, Wis. Stats. 704.07 (4), and unsafe, dilapidated or unsanitary and therefore a human health hazard, Wis. Stats. 254.59 (3), or a presence of lead hazards Wis. Stats. 254.166 (2)

☐ Other action described:

Comments:

Send completed form with clearance dust wipe results to: **DEPARTMENT OF HEALTH SERVICES**
Division of Public Health
Childhood Lead Poisoning Prevention Program
P. O. Box 2659 , Room 145
Madison, WI 53701-2659

WCLPPP Reporting Forms – Medicaid Targeted Case Management Face Sheet – Childhood

Lead Poisoning

DEPARTMENT OF HEALTH SERVICES

Division of Public Health

F-44771AA (10/2014)

STATE OF WISCONSIN

Bureau of Environmental Health

Wis. Stat. § 254.15

(608) 266-5817

FAX: (608) 267-0402

MEDICAID TARGETED CASE MANAGEMENT FACE SHEET – CHILDHOOD LEAD POISONING

This form should be completed when Medicaid Targeted Case Management will be provided to an eligible child. The face sheet provides documentation of additional assessments required for reimbursement for targeted case management that is not included on the Case Report on Children with Elevated Blood Lead Levels.

THIS PAGE DOES NOT NEED TO BE RETURNED TO THE WISCONSIN CHILDHOOD LEAD POISON PREVENTION PROGRAM

CHILD INFORMATION

Name of child receiving targeted case management	Date of birth (mm/dd/yy)
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Medicaid Number

OTHER PROVIDERS INVOLVED IN ASSESSMENT OF THE CHILD

Name and Title	Role in the assessment
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Name and Title	Role in the assessment
----------------	------------------------

Name and Title	Role in the assessment
----------------	------------------------

OTHER HOUSEHOLD MEMBERS RECEIVING CASE MANAGEMENT

Name of client	Name of Case Manager
----------------	----------------------

Name of client	Name of Case Manager
----------------	----------------------

Name of client	Name of Case Manager
----------------	----------------------

ENVIRONMENTAL ASSESSMENT

Date of lead hazard investigation (mm/dd/yy)	Lead hazard investigation report on file <input type="checkbox"/> Yes
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Identify any other safety / health issues in the home that are to be addressed:

FAMILY RESOURCES

Dental care How many times per year does this child see the dentist?	Date of the last dental visit (mm/dd/yy)
--	--

Financial The family reports not having enough money for: <input type="checkbox"/> Food <input type="checkbox"/> Shelter <input type="checkbox"/> Clothing <input type="checkbox"/> Medical needs	Assistance provided to the family to address family financial resources:
--	--

Community The family would like more information on the following topics: <input type="checkbox"/> Child development <input type="checkbox"/> Parenting skills <input type="checkbox"/> Coping with stress <input type="checkbox"/> Recreation <input type="checkbox"/> Employment and training <input type="checkbox"/> Family resource center <input type="checkbox"/> Health care <input type="checkbox"/> Other
--

SIGNATURE - Medicaid Targeted Case Manager	Date Signed (mm/dd/yy)
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ForwardHealth Forms – Prior Authorization Request Form (PA/RF)

DEPARTMENT OF HEALTH SERVICES

ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN

DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable <input type="checkbox"/> HealthCheck "Other Services" <input type="checkbox"/> Wisconsin Chronic Disease Program (WCDP)		2. Process Type	3. Telephone Number — Billing Provider
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)			5a. Billing Provider Number
			5b. Billing Provider Taxonomy Code
6a. Name — Prescribing / Referring / Ordering Provider			6b. National Provider Identifier — Prescribing / Referring / Ordering Provider

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
10. Name — Member (Last, First, Middle Initial)	11. Gender — Member <input type="checkbox"/> Male <input type="checkbox"/> Female	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description		13. Start Date — SOI		14. First Date of Treatment — SOI						
15. Diagnosis — Secondary Code and Description		16. Requested PA Start Date								
17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1 2 3 4				21. POS	22. Description of Service	23. QR	24. Charge
An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.									25. Total Charges	
26. SIGNATURE — Requesting Provider									27. Date Signed	



ForwardHealth Forms – Prior Authorization / Environmental Lead Inspection

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11062 (10/08)

STATE OF WISCONSIN
HFS 107.06(2), Wis. Admin. Code

FORWARDHEALTH PRIOR AUTHORIZATION / ENVIRONMENTAL LEAD INSPECTION

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization / Environmental Lead Inspection Instructions, F-11062A. Refer to the STAT-PA System Instructions, F-11055, for details regarding data entry through the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system.

Providers may call ForwardHealth at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member	2. Date of Birth — Member
3. Member Identification Number	

SECTION II — PROVIDER INFORMATION

4. Provider Name	5. National Provider Identifier
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SECTION III — CLINICAL INFORMATION FOR ENVIRONMENTAL LEAD INSPECTION

6. Member's Blood Lead Level	7. Date of Testing
8. Was a previous lead level test taken by the same member at least 90 days prior to the most recent test with a blood level greater than 15? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Has inspection staff completed the Department of Health Services-approved lead inspection training? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION IV — FOR PROVIDERS USING STAT-PA

10. Procedure Code	11. Diagnosis Code
12. Place of Service	13. Date of Service
14. Total Number of Services Requested	15. Assigned Prior Authorization Number
16. Grant Date	17. Expiration Date

NOTE:

An approved prior authorization (PA) request allows ForwardHealth's reimbursement for two services. This includes initial inspection (T1029, EP — Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling; service provided as part of ForwardHealth's Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] Program) and one follow-up inspection (T1029, EP and TS — Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling; service provided as part of follow-up to ForwardHealth's Early and Periodic Screening, Diagnosis and Treatment [EPSDT] Program **and** follow-up service). Where necessary, one interperiodic visit for education related to lead poisoning may be provided after lead inspection PA has been approved. The code for this is T1002, EP (Registered nurse services, up to 15 minutes; service provided as part of ForwardHealth's Early and Periodic Screening, Diagnosis and Treatment [EPSDT] Program).

SECTION V — SIGNATURE

18. SIGNATURE — Provider	19. Date Signed
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ForwardHealth Forms – Prior Authorization / Environmental Lead Inspection Instructions

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11062A (07/12)

STATE OF WISCONSIN
DHS 107.06(2), Wis. Admin. Code

FORWARDHEALTH PRIOR AUTHORIZATION / ENVIRONMENTAL LEAD INSPECTION INSTRUCTIONS

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

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., 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, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when requesting PA for certain services. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Providers may submit Prior Authorization/Environmental Lead Inspection requests in one of the following ways:

- 1) For Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) requests, providers should call (800) 947-1197.
- 2) For paper PA requests by fax, providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the Prior Authorization/Environmental Lead Inspection form, F-11062, by fax to ForwardHealth at (608) 221-8616.
- 3) For paper PA requests by mail, providers should submit a PA/RF and the PA/Environmental Lead Inspection form to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

Providers should make duplicate copies of all paper documents sent to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Environmental Lead Inspection Information and Requirements (Technical Aspects of Inspections)

1. Determine the most likely sources of high-dose exposure to lead.
2. Investigate the child's home, giving special attention to painted surfaces, dust, soil, and water.
3. Advise parents about identified and potential sources of lead and ways to reduce exposure.
4. Notify the property owner immediately that a child residing on the property has lead poisoning.
5. Monitor the effectiveness and timeliness of abatement procedures closely.
6. Coordinate environmental activities with those of other public health and social management agencies.

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Member

Enter the member's date of birth in MM/DD/CCYY format.

Element 3 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters.

ForwardHealth Forms – Prior Authorization / Environmental Lead Inspection Instructions (continued)

PRIOR AUTHORIZATION/ENVIRONMENTAL LEAD INSPECTION INSTRUCTIONS
F-11062A (07/12)

Page 2 of 2

SECTION II — PROVIDER INFORMATION

Element 4 — Provider Name

Enter the name of the provider who would perform/provide the requested service/procedure.

Element 5 — National Provider Identifier

Enter the National Provider Identifier of the provider performing the service.

SECTION III — CLINICAL INFORMATION FOR ENVIRONMENTAL LEAD INSPECTION

Element 6 — Member's Blood Lead Level

Enter the member's two-digit blood lead level. (If the blood level is a one-digit number, please precede the number with a zero when entering.)

Element 7 — Date of Testing

Enter the date of testing in MM/DD/CCYY format.

Element 8

Check the appropriate box to indicate whether or not the previous lead level test taken by the same member at least 90 days prior to the most recent test had a blood lead level greater than 15.

Element 9

Check the appropriate box to indicate whether or not the inspection staff has completed the Department of Health Services-approved lead inspection training.

SECTION IV — FOR PROVIDERS USING STAT-PA

Element 10 — Procedure Code

Enter procedure code "T1029" (Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling).

Element 11 — Diagnosis Code

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code "984" (Toxic effect of lead and its compounds [including fumes]).

Element 12 — Place of Service

Enter the only allowable place of service code for environmental lead inspection ("12," the child's home).

Element 13 — Date of Service

The date of service may be up to 31 days in the future or up to 14 days in the past. Enter in MM/DD/CCYY format.

Element 14 — Total Number of Services Requested

Enter "1."

Element 15 — Assigned Prior Authorization Number

Record the PA number assigned by the STAT-PA system.

Element 16 — Grant Date

Record the grant date of the PA as assigned by the STAT-PA system.

Element 17 — Expiration Date

Record the date that the PA expires as assigned by the STAT-PA system.

SECTION V — SIGNATURE

Element 18 — SIGNATURE — Provider

The provider must sign this Element.

Element 19 — Date Signed

Enter the date signed in MM/DD/CCYY format.

ForwardHealth Forms – STAT-PA System Instructions

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11055 (10/11)

STATE OF WISCONSIN

FORWARDHEALTH STAT-PA SYSTEM INSTRUCTIONS

The ForwardHealth Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system is an automated voice response system that allows Medicaid-certified providers to receive prior authorization (PA) via telephone rather than by mail or the Web. Providers answer a series of questions and receive an immediate response of an approved or returned PA.

Providers communicate with the STAT-PA system by entering requested information on a touch-tone telephone keypad or by calling Provider Services. Providers must have their provider number to access the STAT-PA system.

The STAT-PA system is available by calling one of the following telephone numbers:

- **Touch-Tone Telephone**
(800) 947-1197
Available 24 hours a day, seven days a week.
- **Provider Services**
(800) 947-9627
Available from 7:00 a.m. to 6:00 p.m., Monday through Friday, excluding state-observed holidays.

REQUIRED INFORMATION

All providers using STAT-PA are required to provide the following information:

- Provider number.
- Practice Location ZIP+4 code.
- Member identification number.
- National Drug Code (NDC) or procedure code.
- *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code.
- Place of Service (POS) code.
- First date of service (DOS).
- Days supply or total number requested.

Note: When requesting a drug, prescribing provider information is required. Additionally, if a National Provider Identifier (NPI) is entered, and the requesting provider is not a retail pharmacy, the taxonomy code is required.

HOW TO USE WISCONSIN STAT-PA

1. Complete the appropriate PA attachment form.
2. Select mode of transmission (touch-tone telephone or Provider Services).

TOUCH-TONE TELEPHONE REQUESTS

To use a touch-tone telephone to submit a PA request:

1. Call (800) 947-1197. This connects the provider directly with the STAT-PA system.
2. When the system answers, it will ask a series of questions that providers answer by entering the information on the telephone keypad. The service-specific PA attachments list the information needed in the order it is requested by the STAT-PA system.

Note: When using a touch-tone telephone to enter the NPI, taxonomy code, member ID, NDC or procedure code, ICD-9-CM diagnosis code, POS code, requested first DOS, and quantity, always press the pound (#) key to mark the end of the data just entered. The pound (#) key signals the system that the provider has finished entering the data requested and ensures the quickest response from the system.

Providers may be asked to enter alphabetic data, which can be entered by using the asterisk (*) key. For example, a provider is asked to enter a procedure code such as L3216. The first character is an alpha character; therefore, the provider presses the single asterisk (*) key followed by the two digits that indicate the letter. The first digit is the number on the keypad where the letter is located, and the second digit is the position of the letter on that key. For example: Procedure code L3216 should be entered as *53 3 2 1 6.

Alphabet Key:

A = *21	G = *41	M = *61	S = *73	Y = *93
B = *22	H = *42	N = *62	T = *81	Z = *12
C = *23	I = *43	O = *63	U = *82	
D = *31	J = *51	P = *71	V = *83	
E = *32	K = *52	Q = *11	W = *91	
F = *33	L = *53	R = *72	X = *92	

ForwardHealth Forms – STAT-PA System Instructions (continued)

STAT-PA SYSTEM INSTRUCTIONS
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3. Once all data have been entered completely, STAT-PA processes the information, indicates the status of the PA request, and gives providers the chance to finalize, cancel, or change their entered information. Once the PA request is finalized, STAT-PA indicates the PA number and, if approved, the effective dates and authorized number of services.

Once familiar with the STAT-PA system, providers may enter the PA information in the designated order immediately — there is no need to wait for the full voice prompt. Providers may key information at any time, even when the system is processing information. The system automatically proceeds to the next function.

PROVIDER SERVICES REQUESTS

Providers who do not have a touch-tone telephone may call Provider Services at (800) 947-9627. The Provider Services correspondent will access STAT-PA and enter the required data requested from the provider.

Provider Services is available to all STAT-PA users. Providers who are experiencing difficulties with the system can select to be transferred to Provider Services for assistance.

DOCUMENTATION INFORMATION

Providers must maintain all documentation that supports medical necessity, claim information, and delivery of the approved service(s) in their records for a period not less than five years. Regardless of what STAT-PA method is used, providers will receive a letter by mail indicating the assigned PA number and the STAT-PA decision. Providers with a secure ForwardHealth Portal account will also receive a copy of this letter in their portal mailbox. This letter should be maintained as a permanent record of the transaction.

Helpful Hints

- The provider is given three attempts at each field to correctly enter the requested data. If those attempts are unsuccessful, the provider can select to be transferred to Provider Services for assistance, or the call will be terminated.
- Providers are given two attempts to enter data within 10 seconds. If those attempts are unsuccessful, the provider can select to be transferred to Provider Services for assistance, or the call will be terminated.
- Providers are allowed 25 PA requests per connection for touch-tone telephone.
- Providers are allowed up to 25 minutes per connection for touch-tone telephone.
- The decimal point for diagnosis codes is not required when entering a STAT-PA request by touch-tone telephone; however, all digits of the codes must be entered.
- The first date of service entered by the provider may be up to 31 calendar days in the future or up to 14 days in the past.
- Providers who need to end date a PA request due to a change in prescription may do so through STAT-PA if the request was originally submitted through STAT-PA. If a provider needs assistance with the end date process, the provider may select to be transferred to Provider Services for assistance.

Provider Services and Resources

Services and resources, contact information, and hours of availability are effective after ForwardHealth implementation, unless otherwise noted.

ForwardHealth Portal	www.forwardhealth.wi.gov/	24 hours a day, seven days a week
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	(800) 947-3544	24 hours a day, seven days a week
<p>WiCall, the ForwardHealth Automated Voice Response system, provides responses to the following inquiries:</p> <ul style="list-style-type: none"> • Checkwrite. • Claim status. • Prior authorization. • Member enrollment. 		
ForwardHealth Provider Services Call Center	(800) 947-9627	Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)*
<p>To assist providers in the following programs:</p> <ul style="list-style-type: none"> • BadgerCare Plus. • Medicaid. • SeniorCare. • Wisconsin Well Woman Medicaid. • Wisconsin Chronic Disease Program (WCDP). • Wisconsin Well Woman Program (WWWP). • Wisconsin Medicaid and BadgerCare Plus Managed Care Programs. 		
ForwardHealth Portal Helpdesk	(866) 908-1363	Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Time)*
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	(866) 416-4979	Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Time)*
<p>For providers, trading partners, billing services, and clearing houses with technical questions about the following:</p> <ul style="list-style-type: none"> • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software. 		
Managed Care Ombudsman Program	(800) 760-0001	Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)*
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	(800) 362-3002	Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)*
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		

* With the exception of state-observed holidays.