DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00406 (02/2025)

STATE OF WISCONSIN
Wis. Stat. § 49.45(9)
Wis. Admin. Code § DHS 104.03

PHARMACY SERVICES LOCK-IN PROGRAM
HMO MEMBER DESIGNATION OF PHARMACY

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

Members 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 ID number per Wis. Admin. Code § DHS 104.02(4).

Under Wis. Stat. § 49.45(4), personally identifiable information about applicants and members is confidential and is used for purposes directly related to the administration of the program such as determining the 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 services.

INSTRUCTIONS: Type or print clearly. Complete all information requested on this form and return it in the envelope provided.

Talk to the pharmacist you wish to select before choosing that pharmacy to manage your care. The pharmacy you select will be contacted by the Pharmacy Services Lock-In Program and must agree to serve as lock-in pharmacy for you before they will be assigned.

Completed forms should be returned by mail to Pharmacy Services Lock-In Program, c/o Acentra, PO Box 3570, Auburn, AL 36831-3570.

SECTION I – MEMBER INFORMATION

I, _____, designate the following provider as my Pharmacy Services
(Print your first and last name here.)

Lock-In pharmacy for the purpose of obtaining restricted medications services under Wisconsin Medicaid, BadgerCare Plus, or SeniorCare.

Member ID Number	Phone Number – Member

Address – Member (Street, City, State, Zip Code)

SECTION II – LOCK-IN PHARMACY FOR FILLING PRESCRIPTIONS FOR RESTRICTED MEDICATIONS

Name – Pharmacy	Phone Number (Include Area Code) – Pharmacy

Address – Pharmacy (Street, City, State, Zip+4 Code)

SECTION III – MEMBER SIGNATURE

I have been informed of the health care provider restriction process and the reasons for the restriction. I have selected the pharmacy named above for restriction purposes.

SIGNATURE – Member	Date Signed – Member

Reset Form