DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-03203 (09/2024)

STATE OF WISCONSIN
Wis. Stat. § 49.45

WISCONSIN MEDICAID

DISENROLLMENT OF ADULT LONG-TERM CARE (LTC) WAIVER PROGRAMS AND SERVICES

INSTRUCTIONS: Type or print clearly. All providers must fill out Sections I and II. Complete Section III if this form is being submitted by a third party, such as a managed care organization (MCO) or IRIS (Include, Respect, I Self-Direct) fiscal employer agency (FEA) on behalf of a provider.

SECTION I – PROVIDER INFORMATION

1. Name – Provider (Organization or Individual)

2. Provider Medicaid ID

3. Name – Person Completing the Form

SECTION II – ADULT LTC WAIVER SERVICES OR PROGRAMS FOR DISENROLLMENT

4. Program(s) to Remove

- ❑ IRIS
- ❑ Family Care
- ❑ Family Care Partnership
- ❑ PACE (Program of All-Inclusive Care for the Elderly)

5. Service(s) to Remove

6. Effective Date of Requested Removal	
7. **SIGNATURE** – Provider	8. Date Signed by Provider (Required even if completed by the Third-Party Delegate)

SECTION III – THIRD-PARTY DELEGATE INFORMATION

9. Name – Third-Party Agency (MCO or FEA)

10. Name – Third-Party Delegate

11. Phone Number – Third-Party Delegate	12. Email Address – Third-Party Delegate
13. **SIGNATURE** – Third-Party Delegate	14. Date Signed by Third-Party Delegate