



FORWARDHEALTH

PROVIDER SERVICES
313 BLETTNER BLVD
MADISON WI 53784

Tony Evers
Governor

Telephone: 800-947-9627
TTY: 711 or 800-947-3529

Karen E. Timberlake
Secretary

State of Wisconsin
Department of Health Services

www.forwardhealth.wi.gov

<Month DD, YYYY>

<sequence number>

<Provider Name> <Title>

<Contact Name>

<Address 1>

<Address 2>

<City> <State> <Zip>-<Zip4>

Dear Wisconsin Well Woman Program Provider Applicant:

Thank you for requesting a Wisconsin Well Woman Program provider certification packet. Once you are a certified provider, you will play a significant part in improving the health of low-income people in your community.

Your application tracking number (ATN) for your certification is <ATN>. Please include your ATN on all correspondence relating to your certification application. Wisconsin Well Woman Program recommends you keep a copy of the completed materials for your records.

Please do the following to complete your certification packet:

1. Review and complete all required documents and applicable optional documents indicated below:

	Item	Required	Optional
1.	Provider Application, F-44725	X	
2.	Provider Agreement, F-13607	X	

2. Attach all completed documents listed in step 1 and any additional materials requested throughout this certification packet to this cover letter. It is important that you return this cover letter with your completed materials to ensure proper tracking of the application process.
3. Return the completed materials to ForwardHealth at Provider Enrollment, 313 Blettner Boulevard, Madison, WI 53784.

Please call Provider Services at (800) 947-9627 if you have questions regarding your certification packet.

Sincerely,

Wisconsin Well Woman Program
Provider Enrollment Department

Enclosures

F-13509 (01/2021)

WISCONSIN WELL WOMAN PROGRAM PROVIDER APPLICATION INFORMATION AND INSTRUCTIONS

The Wisconsin Well Woman Program (WWWP) requires certain information in order to authorize and pay for screening services provided to eligible program 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 in this application may result in denial of payment for services.

The use of this form is voluntary. However, in order to be certified, applicants are required to complete this application and submit it to the following address:

ForwardHealth
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

Applicants may call Provider Services at (800) 947-9627 with questions.

INSTRUCTIONS

Type or print the applicant's information on this application. Complete all sections. If a question does not apply to the applicant, he or she should write "N/A" in the field. Failure to complete all sections of this application will cause delay and may cause denial of certification.

Important Notice: In receiving this application from and granting WWWP certification to the individual or other entity, WWWP relies on the truth of all of the following statements:

1. The individual or other entity submitted this application or authorized or otherwise caused it to be submitted.
2. All information entered on this application is accurate and complete, and that if any of that information changes after this application is submitted, the individual or other entity will timely notify WWWP of any such change.

FOR OFFICE USE ONLY

ATN	Date Requested	Date Mailed
Provider ID	Effective Date	
Provider Type	Provider Specialty	



F-44725

WISCONSIN WELL WOMAN PROGRAM PROVIDER APPLICATION

Instructions: Type or print clearly. Before completing this application, read Information and Instructions.

Type of Application

- Individual
- Organization / Group

This application is for one of the following:

- Initial Certification
- Reinstatement of Previous Provider ID
Previous Provider ID _____
- Change in Ownership
Previous Provider ID _____
Effective Date of Change in Ownership _____

SECTION I — IDENTIFYING INFORMATION AND ADDRESS INFORMATION

A. Identifying Information

Special Instructions

Name — Provider Applicant — Enter only one name. Organizations and groups using a “doing business as” (DBA) must enter the DBA name. The name entered on this line must match exactly the applicant’s name used on all other information supplied to WWWP.

Credentials — Enter the applicant’s credentials.

Date of Birth / Gender / Social Security Number (SSN) — Required for individual applicants only. Enter the date in MM/DD/CCYY format.

Individuals — Applicant Only

Name — Provider Applicant (Last Name, First Name, Middle Initial)

Credentials

Date of Birth

Gender

- Male
- Female

Social Security Number (SSN)

Organizations and Groups — Applicant Only

Name — Provider Applicant

B. National Provider Identifier (NPI)

Special Instructions

NPI — Designate the NPI the provider will use for conducting business with WWWP.

NPI

Continued

SECTION I — IDENTIFYING INFORMATION AND ADDRESS INFORMATION (Continued)

C. Address Information

Special Instructions

Practice Location Information — Enter the complete address, (street, city, state, and ZIP+4 code) where the provider applicant's office is physically located and where records are normally kept. **It is not acceptable to use a drop box or Post Office Box.** Individual applicants employed by a group or agency should indicate their employer's name in Address Line 1.

WWWP Contact Person — Enter the name and telephone number and extension of the WWWP contact person. This information will be used for WWWP administrative purposes only.

Mailing Information — Enter the complete mailing name and address. The WWWP will send general information and correspondence to this address.

Does the applicant work at a clinic or as part of a group? Yes No

If Yes, what is the clinic / organization's NPI? _____

Practice Location Information

Address Line 1 — Practice		Address Line 2 — Practice	
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City	State	ZIP Code	ZIP+4 Extension
------	-------	----------	-----------------

County	Name — WWWP Contact Person
--------	----------------------------

Telephone Number — WWWP Contact Person ()	Ext.
--	------

Mailing Information

Name	Name — Contact Person
------	-----------------------

Address Line 1		Address Line 2	
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City	State	ZIP Code	ZIP+4 Extension
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Continued

SECTION II — ADDITIONAL INFORMATION

Special Instructions

Respond to all applicable items:

- Applicants who are licensed are required to complete Element 1.
- Applicants who will submit claims for laboratory tests are required to complete Element 2.

1. Individual or Organization License and State of License

2. Clinical Laboratory Improvement Amendment (CLIA) Number

SECTION III — PROVIDER FINANCIAL INFORMATION

Special Instructions

Taxpayer Identification Number (TIN) — Enter the TIN that should be used to report income to the Internal Revenue Service (IRS). The number entered must be the TIN of the taxpayer name entered. The taxpayer's name and TIN must match exactly what is on record with the IRS.

Name — Taxpayer — Enter the taxpayer's name for the TIN exactly as it is recorded with the IRS. The WWWP will generate payments using the taxpayer's name. Individuals reporting income to the IRS under an SSN must enter the individual name recorded with the IRS for the SSN.

TIN Type — Check whether the TIN is an EIN or SSN.

TIN Effective Date — Enter the date the TIN became effective for the applicant.

TIN End Date — Enter the date the TIN ends.

Checks and Remittance Advice Address — Enter the complete address to which check and remittance advices should be mailed.

Name — Financial Contact Person — Enter the name of the financial contact person.

Telephone Number — Contact Person — Enter the telephone number of the contact person.

1099 Mailing Address — Enter the complete address to which the IRS Form 1099 should be sent.

Taxpayer Information

Taxpayer Identification Number (TIN)		Name — Taxpayer	
TIN Type	TIN Effective Date	TIN End Date	
<input type="checkbox"/> EIN <input type="checkbox"/> SSN			

Checks and Remittance Advice Information

Address Line 1		Address Line 2	
City	State	ZIP Code	ZIP+4 Extension
Name — Financial Contact Person		Telephone Number — Contact Person	

1099 Mailing Address

Address Line 1		Address Line 2	
City	State	ZIP Code	ZIP+4 Extension

SECTION IV — TYPE OF CERTIFICATION

Check the provider type for this application from the list below. A separate application is required (in most cases) for each provider type for which the provider wishes to be certified. An individual may choose only one provider type per application.

- | | |
|---|---|
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Nurse Services |
| <input type="checkbox"/> Anesthesiology Assistant* | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Anesthetist / Certified Registered Nurse Anesthetist | <input type="checkbox"/> Physician (See Below) |
| <input type="checkbox"/> Family Planning Clinic | <input type="checkbox"/> Physician Assistant* |
| <input type="checkbox"/> Federally Qualified Health Center | <input type="checkbox"/> Physician Group / Clinic (See Below) |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Portable X-ray |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Rural Health Clinic |
| <input type="checkbox"/> Certified Nurse Midwife (Master's Level or Equivalent) | <input type="checkbox"/> Free Standing |
| <input type="checkbox"/> Certified Family Nurse Practitioner | <input type="checkbox"/> Hospital Affiliated |
| <input type="checkbox"/> Other Nurse Practitioner | |

* Individuals must be supervised and cannot independently bill WWWP. In most cases, the clinic must submit claims.

Physicians and physician groups must indicate a specialty below. (Select one specialty.)

- | | |
|---|--|
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Internal Medicine |
| <input type="checkbox"/> Clinic (Multi-specialty) | <input type="checkbox"/> Obstetrics and Gynecology |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> General Practice | <input type="checkbox"/> Preventive Medicine |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Radiology |

SECTION V — APPLICANT'S TYPES OF BUSINESS

Applicant's Type of Practice (Check appropriate box.)

Individual

Sole Proprietor

County and State Where Registered _____

Corporation for Nonprofit

Limited Liability

Corporation for Profit

State of Registration _____

Names of Corporate Officers _____

Partnership

State of Registration _____

Names of All Partners and SSNs (Use additional sheet if needed.)

Name _____ SSN _____

Name _____ SSN _____

Government (Check one.)

County Agency

State Agency

Municipality (City, Town, Village)

Tribal Agency

City / County Agency

SECTION VI — TAXONOMY

Special Instructions

Copy this page and complete as needed.

A primary taxonomy code must be on file with WWWP at all times. Additional taxonomy codes are optional.

Primary Taxonomy Code (Required)	Additional Taxonomy Code
Additional Taxonomy Code	Additional Taxonomy Code
Additional Taxonomy Code	Additional Taxonomy Code

SECTION VII — NPI SUBPARTS (Hospital Providers Only)

Special Instructions

Copy this page and complete as needed.

Hospital providers **only** may add NPI subparts in this section. An associated taxonomy code is required for each NPI subpart entered.

NPI Subpart	Associated Taxonomy Code
NPI Subpart	Associated Taxonomy Code
NPI Subpart	Associated Taxonomy Code
NPI Subpart	Associated Taxonomy Code
NPI Subpart	Associated Taxonomy Code



PROVIDER PARTICIPATION AGREEMENT — February 2008

The following program and administrative specifications are required as a condition of this Agreement. The full complement of screening program services includes program-approved Wisconsin Well Woman Program (WWWP) screening, re-screening, and diagnostic procedures, individual case management, and follow-up services.

By signing this Agreement,

(Provider's Name and Number [if assigned]. Name **must** exactly match the name used on **all** other documents.)

hereinafter referred to as the Provider, whether an individual, agency, or other entity, agrees to meet and abide by the terms and conditions of the WWWP Policy and Procedures Manual, PPH 43029, and this Agreement.

SECTION I — GENERAL REQUIREMENTS

1. This Agreement shall be effective February 01, 2008, upon approval by the WWWP, and shall continue in effect until June 30, 2012, or such time as either party terminates the Agreement in accordance with the process described in paragraphs 2 and 3 of this Agreement.
2. Except as provided in paragraph 3, either party may terminate this Agreement with or without cause. Thirty-day written notice from the WWWP to a Provider or vice versa will terminate this Agreement. The WWWP will notify the fiscal agent of the termination date.
3. If the Provider is in violation of this Agreement or any other federal or state law, the Wisconsin Department of Health Services (DHS), Division of Public Health (DPH), the WWWP may immediately terminate this Agreement. In the event of termination, the Department shall reimburse the Provider for services provided prior to the termination date.
4. The Provider must comply with applicable federal and state laws prohibiting discrimination in the delivery of service on the basis of race, color, disability, creed, national origin, ancestry, sexual orientation, arrest or conviction record, marital status, religion, or payment source and to make available a Client Complaint procedure in the event of such discrimination.
5. The Provider is subject to certain federal and state laws regarding confidentiality and disclosure of medical records or other health information, including the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for all services, information, transactions, including electronic transmissions, privacy, and security regulations.



6. The Department offers, or will offer in the future, the Provider several options for submitting claims and other information to the Department, including electronic and web-based submission methodologies that require the input of secure and discrete access codes but not written provider signatures. The Provider has sole responsibility for maintaining the privacy and security of any access code the Provider uses to submit information to the Department, and any individual who submits information using such access codes does so on behalf of the Provider, regardless whether the Provider gave the access code to the individual or had knowledge that the individual knew the access code or used it to submit information to the Department. The Provider is responsible for repayment to the Department for any overpayment, and is subject to any sanctions that may be imposed by the Department, based on any information submitted by any third party in the Provider's name or provider number or using the Provider's access code, with or without the Provider's knowledge or consent, regardless of the manner in which the information was submitted.
7. The Provider must provide services on behalf of the WWWP in the DHS, as needed, to eligible, enrolled clients. The Provider must adhere to the federal Centers for Disease Control and Prevention (CDC)-required program guidelines for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) contained in the WWWP Policy and Procedures Manual. The WWWP Policy and Procedures Manual is available on the WWWP web site at <http://dhs.wisconsin.gov/womenshealth/wwwp/PolicyandProceduresManual.htm>. The WWWP local coordinating agencies (LCAs) are available to provide training or clarification on WWWP guidelines and are a vital link to assist providers with case management services for WWWP enrolled women. Frequent communication between the Provider and the LCA is crucial to the success of local programming. A directory of LCAs is available on the WWWP web site at <https://www.dhs.wisconsin.gov/wwwp/counties.htm>.
8. The Provider must designate at least one person at each site who is responsible for providing and disseminating WWWP information to appropriate staff within the provider's facility and to eligible or potentially-eligible WWWP clients. The Provider must specify the name of the contact person on the Agreement application. Any changes in the contact person must be reported to the WWWP within 30 days.
9. The Provider must track WWWP-enrolled women who have normal screening results as set forth in this Agreement and as delineated in the WWWP Policy and Procedures Manual.
10. The Provider must assure timely and appropriate case management and follow-up services for all WWWP-enrolled women who have abnormal screening results following guidelines set forth in this Agreement and as delineated in the WWWP Policy and Procedures Manual. The Provider will determine the frequency and type of clinical diagnostic follow-up needed for abnormal breast and cervical findings according to prevailing national practice guidelines, such as those published by the National Comprehensive Cancer Network (<http://www.nccn.org>), the American Society for Colposcopy and Cervical Pathology (<http://www.asccp.org>), the American College of Obstetricians and Gynecologists (ACOG), the American Cancer Society (ACS), the American College of Radiology (ACR), the U.S. Preventive Services Task Force (USPSTF), and other guidelines specified by the Program.
11. The Provider must comply with all the WWWP data submission and reporting requirements as outlined in Section III of this Agreement and in the WWWP Policy and Procedures Manual.
12. The Provider must ensure documentation of the results of all WWWP-approved services, as well as case management activities, performed on an eligible woman is placed in the individual client's permanent medical record.

13. The Provider must maintain adequate and complete fiscal and medical records to fully document services provided to clients under terms of this Agreement. The Provider must retain WWWP client records for a minimum of five years and make them available upon request by an authorized representative of the WWWP. Failure to retain adequate documentation for any service billed may result in recovery of payments for services not adequately documented.
14. The Provider must participate in public and professional education activities conducted or sponsored by the WWWP.
15. The Provider must participate with the WWWP LCA in recruiting and retaining WWWP clients through in-reach and outreach activities.
16. The Provider must utilize only laboratories that meet and comply with the Clinical Laboratory Improvement Act (CLIA) standards.
17. The Provider must utilize mammography units certified by the Food and Drug Administration (FDA) that meet requirements of the Mammography Quality Standards Act and maintain evidence of this certification on file.
18. Obligations under the Agreement shall be suspended at such time as funds are not available to cover payment for services provided to eligible clients. However, suspension shall not eliminate payment under this Agreement for services that had been approved by the WWWP and that had already been furnished prior to the date of suspension.
19. The Provider agrees to indemnify, defend, and hold harmless the State of Wisconsin and its agents, officers, and employees from all claims and suits, including court costs, attorney fees, and other expenses caused by any act or omission of the Provider and/or its subcontractors, if any.

SECTION II — WWWP PROVIDER CERTIFICATION REQUIREMENTS

20. A WWWP Provider must meet professional licensure standards and be certified as a Wisconsin Medicaid provider.
21. Wisconsin Well Woman Program laboratories must be certified by the Centers for Medicare and Medicaid Services (CMS) and meet CLIA requirements. Laboratories must be Medicare Part A and Medicare Part B certified.
22. Wisconsin Well Woman Program mammography providers must be certified by the FDA and meet the requirements of the Mammography Quality Standards Act (MQSA).
23. Hospitals (outpatient) must be Medicare and Medicaid certified.

SECTION III — PROVIDER RESPONSIBILITIES

Enrollment

24. A WWWP Provider will enroll clients **only** as delegated by written agreement with the LCA. A listing of LCAs is available on the WWWP web site at <https://www.dhs.wisconsin.gov/wwwp/counties.htm>.

If the Provider enrolls clients, the Provider must complete and sign the WWWP Enrollment Form, documenting evidence of the client's program eligibility (e.g., residency, age, income, insurance status). The Provider must retain a copy of the completed Enrollment Form in the client's medical record and send copies to the LCA and the WWWP within 10 business days.

Covered Services

25. The WWWP covers only specified screening procedures related to breast and cervical cancer as listed in the WWWP Policy and Procedures Manual. A list of WWWP-covered services is also available on the WWWP Web site at www.dhs.wisconsin.gov/publications/p0/p00276.pdf.
26. The Provider must accept WWWP payments for covered services as payment in full, except as required of third parties. The WWWP Provider must provide specific WWWP covered services at no charge to enrolled clients. Providers who make referrals to other health care providers for covered screening or diagnostic services must be sure to refer to other WWWP-approved providers. If the WWWP Provider recommends services or procedures not covered by the WWWP, the Provider must inform the client that she is responsible for paying for the service, **prior** to performing the service.

Reporting

27. The WWWP Provider must document the results of all screening and diagnostic procedures, follow-up recommendations, diagnosis, client notification, and case management actions, including client refusal in the client's medical record. The WWWP Provider must complete all required data sections on the WWWP screening activity and diagnostic reporting forms and submit copies to the WWWP. The Provider must establish and report a final diagnosis and recommendations for all breast and cervical abnormalities to the WWWP. If treatment is needed, the Provider must report the treatment status. If cancer is found, the Provider must also report tumor stage and size, when indicated. Wisconsin Well Woman Program Providers who refer for follow-up must request copies of the final diagnosis, recommendations, and treatment status and report the findings to WWWP.
28. The WWWP Provider must also send copies of all completed screening activity and diagnostic reporting forms to the LCA within 10 business days to facilitate coordination of care and case management.
29. Wisconsin Well Woman Program Providers must use the ACR, Breast Imaging Reporting and Data System (BIRADS) for reporting the interpretation of mammography examinations and the "Bethesda" Reporting System for reporting Pap smear results.

Follow-up and Case Management of Abnormal Results for Breast or Cervical Cancer Screening

30. Wisconsin Well Woman Program Providers must establish and maintain systems to ensure enrolled women with abnormal or suspicious screening results get timely access to accepted and appropriate follow-up care and treatment.

31. The WWWP Provider must offer to provide case management services to all women with abnormal screening results. The responsibility for case management is shared between the Provider and the LCA.
32. The WWWP Provider must contact the LCA within 10 business days after an abnormal screening result to communicate recommendations for client follow-up appointments and/or referrals. The LCA can assist the Provider with client case management needs.
33. The WWWP Provider must provide or arrange for further diagnostic evaluation for the following results:
 - All abnormal clinical breast exams, independent of the mammography results.
 - All abnormal mammogram results, independent of clinical breast exam findings.
 - All Pap tests that show potential malignant or pre-malignant findings.
34. The WWWP Provider must notify the client and her primary care provider of abnormal screening results. At a minimum, the Provider must make at least three notification attempts. The Provider must have an effective communication system and document written and verbal communication in the client's medical record. The Provider must keep the LCA informed of notification and case management concerns:
 - *First attempt:* Reports by telephone and by letter, as soon as possible to avoid delays in client work-up, of the screening date, **all** abnormal results, and recommendations for follow-up to the client's referring primary care provider and to the client. (For example, refer to the Mammography Quality Standards Act regulations for details on communication of mammography results to clients and health care providers). If the client does not have a primary care provider, the WWWP Provider and LCA must assure that the client receives appropriate notification and follow-up. Notification of abnormal results must be made directly to the client in writing with explanations in lay terms. Clients should be notified about the benefits of receiving, and the consequences of refusing, follow-up services.
 - *Second attempt:* If there has not been a response from the client or her primary care provider within 30 days of the initial notification attempt, the WWWP Provider must send a second follow-up letter to the client and her primary care provider. The WWWP Provider must also attempt to reach both parties by telephone. Wisconsin Well Woman Program providers are encouraged to use certified letters for legal purposes.
 - *Third attempt:* If there has not been a response to the second follow-up letter within 14 days, the WWWP Provider must notify the LCA to seek assistance with follow-up. The WWWP Provider must give the LCA the following information: client's name, date of birth, identification number, address, telephone number, provider name, dates of service, reason for follow-up, and report of follow-up attempts made.
35. The WWWP Provider must complete the appropriate screening activity and diagnostic reporting forms and send copies to the WWWP and the LCA within 10 business days. Please also refer to the section on reporting in this Agreement and to the WWWP Policy and Procedures Manual for more specifics on required reporting.
36. The WWWP Provider must ensure clients with an abnormal mammogram, abnormal clinical breast exam, or abnormal Pap test receive a final diagnosis within 60 days of the abnormal screening, unless the client refuses follow-up.

37. The WWWP Provider must ensure clients initiate treatment within 60 days of a final diagnosis of breast or cervical cancer or pre-cancerous cervical lesion, unless the client refuses follow-up or treatment.

Tracking and Follow-up of Normal Results for Breast or Cervical Cancer Screening

38. The WWWP Provider must document results of screening procedures, client notification, and recommend re-screening dates in the client's medical record.
39. The WWWP Provider must report required data on the client's screening history, procedure results, and recommendations on the appropriate screening activity reporting forms and submit copies to the WWWP. The Provider must also send copies of all completed reporting forms to the LCA.
40. The WWWP recommends that service providers establish systems (e.g., letters, postcards, phone calls) to inform clients and their primary health care provider of their normal screening results.
41. The WWWP providers are encouraged to inform clients of recommended re-screening intervals, when the results are normal.

SECTION IV — PROVIDER BILLING AND REIMBURSEMENT-RELATED REQUIREMENTS

42. Payments to providers for services shall be in compliance with the WWWP reimbursable services and rates at the time of service delivery.
43. The WWWP shall reimburse providers based on the allowable Medicare reimbursement rate.
44. The WWWP is the payer of last resort. The WWWP Provider must determine if women, eligible under the WWWP, have third-party reimbursement that covers screening for any WWWP-approved services and bill such parties before billing WWWP.
45. The Provider must not use WWWP funds for treatment services.
46. Services authorized and the resulting charges are subject to review and approval by the WWWP.
47. The WWWP Provider must not require or request payment for authorized services from the enrolled clients themselves.
48. The WWWP Provider **must** notify WWWP clients of services not covered by the WWWP, **prior to performing them**. The Provider may bill clients for services not covered under this Agreement.
49. The WWWP Provider must submit completed screening activity and diagnostic reporting forms with the CMS claim forms to WWWP. The WWWP will reject a claim if any of the required forms are missing or do not include all required data. The WWWP will reject a claim made for a service not covered by the WWWP or if the client is not enrolled in the WWWP. Providers should refer to the WWWP Policy and Procedures Manual or the LCA for additional details on billing and reimbursement and the process for submitting claims.

ALL **SEVEN** PAGES OF THIS PROVIDER AGREEMENT AND ACKNOWLEDGEMENT **MUST BE RETURNED TOGETHER.**

Name — Provider	Provider ID
Address (This is the provider's physical address.)	
Street Address Line 1 _____	
Street Address Line 2 _____	
City _____	
State _____	
ZIP+4 Code _____	

SIGNATURE — Provider or Authorized Representative	Title	Date Signed
--	-------	-------------

FOR DPH USE ONLY (Do not write below this line)	
SIGNATURE	DATE

**MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO.
THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.**

**FORWARDHEALTH
ELECTRONIC BILLING GENERAL INFORMATION**

ForwardHealth has several electronic billing options available for trading partners to submit electronic claims. Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant software is available at no cost for submitting claims to ForwardHealth. For further information or to order free software refer to www.forwardhealth.wi.gov/ or contact Provider Services at (800) 947-9627 or the EDI Department at (866) 416-4979.

Electronic Methods for Submitting Claims to ForwardHealth

The following are the methods for electronic claim submission:

- Provider Electronic Solutions (PES) — HIPAA-compliant free claim submission software:
 - ✓ 837 Health Care Claim: Institutional.
 - ✓ 837 Health Care Claim: Professional.
 - ✓ 837 Health Care Claim: Dental.
 - ✓ 997 Functional Acknowledgement.
 - ✓ 835 Health Care Claim Payment/Advice.
 - ✓ National Council for Prescription Drug Programs 5.1 Telecommunication Standard for Retail Pharmacy Claims.
- RAS/Internet — Allows providers to send their data files to using a direct RAS connection or Web browser.
- Third-Party Biller — Providers have the option of purchasing a billing system or contracting with a Third-Party Biller to submit their claims.