

**Wisconsin Well Woman Program (WWWP)
Multiple Sclerosis (MS) Report and Referral**

Information and additional instructions on page 3.

A. Client Information – Must be completed for each form submitted.		
<ul style="list-style-type: none"> Client enrollment must be confirmed before any services can be covered by WWWP. Enrollment must be renewed every 12 months. To confirm enrollment, check with the client's WWWP coordinator. A list of coordinators for WWWP is available on the web at www.dhs.wisconsin.gov/wwwwp 		
1. Last Name	2. First Name	3. Maiden Name
4. Social Security Number (Optional) or Client Identification Number	5. Date of Birth (mm/dd/yyyy)	6. Phone Number
7. Client's WWWP Enrollment Date (mm/dd/yyyy)	8. County	9. Native American Tribe (give name if applicable)

B. WWWP Coordinator Information – Case Management for High-Risk Client		
To be complete, this Form must include the client information, confirmed enrollment, and WWWP coordinator information.	<ul style="list-style-type: none"> Copy of Form + referral notes → PCP Copy of Form → WWWP-MS* for reimbursement 	
10. WWWP Coordinating Agency	11. Coordinator's Name	12. Coordinator's Phone Number
13. Case management provided by assisting client with referral for MS services:		
<input type="checkbox"/> Primary Care Provider Name: _____	Date Referred: _____	
<input type="checkbox"/> MS Center Name: _____	Date Referred: _____	
<input type="checkbox"/> NMSS-WI for support services to get to MS Center for diagnosis	Date Referred: _____	
14. "Testing for the WWWP Client" page given to client: <input type="checkbox"/> Yes <input type="checkbox"/> No		

C. Primary Care Provider Information- Initial MS Assessment (See WWWP MS Assessment: Services and Rates)	
To be complete, this Form must include the client information, confirmed enrollment in WWWP, and primary care provider information.	<ul style="list-style-type: none"> Copy of Form + referral notes → MS Center Copy of Form + claim → WWWP-MS* for reimbursement Copy of Form → WWWP coordinator if client assistance needed
15. Provider/Clinic Name (print)	16. Provider/Clinic City (print)
17. Beginning Multiple Sclerosis Assessment Date (mm/dd/yyyy)	18. Performing Provider (print)
19. Findings of Initial MS Assessment (check all that apply)	
<input type="checkbox"/> Within normal limits <input type="checkbox"/> Signs of some other condition (not MS) <input type="checkbox"/> High-risk signs of multiple sclerosis <input type="checkbox"/> Previous diagnosis of MS and needs help with MS treatment	
20. Referred to participating MS Center (check one)	
<input type="checkbox"/> UW Health MS Clinic Additional Centers may participate in the future.	

21. "Testing for the WWWP Client" page given to client: <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Referred to WWWP coordinator for assistance getting to MS Center for testing: <input type="checkbox"/> Yes <input type="checkbox"/> No
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D. MS Center Information - MS Diagnostic Testing (See WWWP MS Assessment: Services and Rates)

To be complete, this Form must include the client information, referring PCP information, and MS Center information.	<ul style="list-style-type: none"> • Copy of Form + clinical notes → referring PCP • Copy of Form + clinical notes + claim → WWWP-MS* for reimbursement
23. MS Center Name (print)	24. Performing Provider Name (print)
25. Initial MS Consultation Date (mm/dd/yyyy)	26. Final Diagnosis Date (mm/dd/yyyy)
27. Final diagnosis (check all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> MS confirmed <input type="checkbox"/> MS suspected, not confirmed <input type="checkbox"/> Other health condition (non-MS) <input type="checkbox"/> Within normal limits 	
28. Recommended follow-up after Final Diagnosis (check all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> MS treatment <input type="checkbox"/> Additional MS testing in future if another MS episode <input type="checkbox"/> Follow-up for other health condition (non-MS diagnosis or treatment) <input type="checkbox"/> No follow-up needed at this time 	29. MS Treatment Status after Final Diagnosis (check one only) <ul style="list-style-type: none"> <input type="checkbox"/> MS - treatment started and date: _____ / _____ / _____ (mm) (dd) (yyyy) <input type="checkbox"/> MS - treatment refused <input type="checkbox"/> MS - lost to follow-up

Submitting Claims for Reimbursement: Providers must submit the claim for services and a completed copy of this WWWP MS Report and Referral Form (and clinical notes when indicated) to be reimbursed. Submit claims and Forms to: WWWP-MS, WI Division of Public Health, PO Box 2659, Madison, WI 53701

Information and Additional Instructions WWWP Multiple Sclerosis (MS) Report and Referral

Information:**Authority And Use:**

The Department of Health and Family Services - Wisconsin Well Woman Program (WWWP) has the authority to collect personally identifiable information necessary to determine eligibility for services for the WWWP. The personally identifiable information collected on this form will **only** be used to determine eligibility for services and reimbursement for providers for covered services.

Privacy:

The Wisconsin Well Woman Program and its participating providers must be HIPAA compliant. This includes protecting the privacy of medical information for clients served by WWWP. The WWWP website has more information on HIPAA procedures for providers for WWWP:

Website: www.dhs.wisconsin.gov/wwwwp/

Instructions:

At this time, this Form can only be completed and submitted as a "hard copy". Please print clearly. For additional copies of this Form, blank copies of this Form can be photocopied, or additional copies are available from WWWP at:

Phone: 608-266-9391

Website: www.dhs.wisconsin.gov/wwwwp/

Social Security Number or Client Identification Number for WWWP:

The client's social security number is optional and will only be used to determine eligibility for WWWP services and eligibility for other health care programs. Clients who do not have or do not provide a social security number will be assigned a WWWP Client Identification Number by the WWWP coordinator for their county/tribe of residence.

WWWP Coordinator List:

To contact a client's WWWP coordinator, to confirm the client's enrollment, or to help with referrals related to MS services, a list of coordinators for WWWP is available from WWWP at:

Phone: 608-266-9391

Website: www.dhs.wisconsin.gov/wwwwp/

WWWP MS Assessment Services and Rates:

The current list of WWWP-covered services and reimbursement rates for MS services, and the MS Staged Assessment Tool for WWWP Providers are available from WWWP at:

Phone: 608-266-9391

Website: www.dhs.wisconsin.gov/wwwwp/

MS Centers Participating in WWWP Staged Assessment for MS:

The current list of MS Centers participating in the WWWP staged assessment and providing MS diagnostic testing is available from WWWP at:

Phone: 608-266-9391

Website: www.dhs.wisconsin.gov/wwwwp/

Submitting Required Copies of Form:

After providers complete their necessary sections of this Form, the completed Form should be photocopied to share with the specified parties (Referral providers, WWWP, WWWP coordinator).

Submitting Claims for Reimbursement:

Providers must submit the claim and a copy of the completed WWWP MS Report and Referral Form to be reimbursed for WWWP MS services. At this time, only hard copies of claims and MS Forms can be accepted. Submit claims for MS services, clinical notes as directed, and the WWWP MS Report and Referral Form to:

WWWP-MS

WI Division of Public Health

PO Box 2659 Madison, WI

53701