

# PREScription VOLUME ATTESTATION SURVEY COMPLETION INSTRUCTIONS

## Overview

### Purpose of the Prescription Volume Attestation Survey

The Wisconsin Department of Health Services (DHS) has engaged Mercer Government Human Services Consulting (Mercer), in conjunction with Hewlett Packard Enterprise, to collect calendar year 2016 prescription volume attestations from Medicaid-enrolled providers for each of their locations.

Provider participation and timely response is required as the information collected will be used to assign the appropriate professional dispensing fee reimbursement rate in ForwardHealth interChange, the DHS claims processing system, for dates of service (DOS) on and after April 1, 2017. Submit any questions about the attestation survey via email to [CODSurvey@mercer.com](mailto:CODSurvey@mercer.com) or call Mercer at 844-294-9982.

**Completed surveys must be received no later than February 3, 2017.**

### Required Participants

All Wisconsin Medicaid-enrolled providers who dispense covered outpatient drugs are required to participate in the Prescription Volume Attestation Survey.

### How to Submit Completed Surveys

Surveys may be completed online at <https://survey.mercer.com/WI2017Attest.aspx>. A username and password to access the online survey was sent to providers in the letter accompanying the Prescription Volume Attestation Survey. Providers may call 844-294-9982 for assistance with the assigned password.

If the provider is unable to submit the survey online, he or she may download the Microsoft® Excel version of the survey from the ForwardHealth website, <https://www.forwardhealth.wi.gov/WIPortal/content/Provider/medicaid/pharmacy/codp/codp.htm.spage>, and submit the completed survey via one of the following:

- Email to [CODSurvey@mercer.com](mailto:CODSurvey@mercer.com)
- Fax to 612-642-8686, Attn: Tim Lillehaugen

Providers who have requested that survey communications be sent to them by mail may opt to complete the paper copy of the survey they received in the mail and submit the completed survey via the above email address or fax number.

Completed surveys must be received no later than **February 3, 2017**. Providers who have not submitted the survey by this date will be assigned to the lowest professional dispensing fee reimbursement rate offered by ForwardHealth.

### Attesting for Multiple Locations

Providers who have multiple locations are required to attest for each location individually. The Microsoft® Excel version of the survey enables providers to submit a single survey document for multiple locations.

## SECTION I – FINANCIAL INFORMATION

The purpose of the Financial Information section is to report calendar year 2016 annual prescription volume that ForwardHealth will use to assign the appropriate professional dispensing fee reimbursement rate for DOS on and after April 1, 2017.

### Element 1 – Total Annual Prescription Volume

Enter the total number of **all** prescriptions dispensed, not just Medicaid prescriptions, for DOS during the 2016 calendar year. Only report prescription volume for DOS under the current ownership, if less than the full calendar year.

### Element 2 – Total Annual Wisconsin Medicaid Prescription Volume

Enter the total number of all Wisconsin Medicaid, BadgerCare Plus, and SeniorCare prescriptions dispensed to members for DOS during the 2016 calendar year.

Wisconsin AIDS Drug Assistance Program (ADAP) providers who are not Medicaid-enrolled should enter 0 in this element.

### Element 3 – Reported Date Range

Enter the 2016 date range for the reported prescription volume if different than January 1, 2016, through December 31, 2016. For changes in ownership during calendar year 2016, enter the date range for the reported prescription volume under the current ownership.

*Note:* Mercer will use reported data for less than a full calendar year to project a full year of data.

## SECTION II – PROVIDER INFORMATION

The purpose of the Provider Information section is to report provider-specific information used for identification.

### Element 4 – Provider Name

Enter the name of the Wisconsin Medicaid provider.

**Element 5 – Wisconsin Medicaid ID Number**

Enter the eight- or nine-digit Wisconsin Medicaid provider number.

**Element 6 – National Provider Identifier (NPI)**

Enter the National Provider Identifier (NPI) of the Wisconsin Medicaid provider.

**Element 7 – Address (Street, City, State, ZIP Code)**

Enter the street address, suite or second address (if applicable), address suite or mail stop, city, state, and nine-digit ZIP code where the prescriptions were dispensed. If the four-digit extension of the ZIP code is unknown, enter 0000; do not use dashes or spaces.

**Element 8 – Telephone Number**

Enter the telephone number, including area code, where the provider may be reached.

**Element 9 – Email Address**

Enter the email address where the provider may be reached.

**Element 10 – Fax Number**

Enter the fax number, including area code, where the provider may be reached.

**SECTION III – CERTIFICATION**

This survey requires the signature of the provider or an individual who has the authority to represent the provider and can attest that the provided information is true, correct, and complete.

**Element 11 – Preparer Signature**

Enter the signature of the preparer.

**Element 12 – Date**

Enter the date the survey was signed.

**Element 13 – Preparer Name**

Print or type the name of the preparer.

**Element 14 – Preparer Title/Position**

Print or type the title or position of the preparer.

**Element 15 – Preparer Address (Street, City, State, ZIP Code)**

Enter the street address, suite or second address (if applicable), address suite or mail stop, city, state, and five-digit ZIP code where the preparer of this survey receives mail.

**Element 16 – Preparer Telephone Number**

Enter the telephone number, including area code, where the preparer of this survey may be reached.

**Element 17 – Preparer Email Address**

Enter the email address where the preparer of this survey may be reached.