PRESCRIPTION VOLUME ATTESTATION SURVEY INSTRUCTIONS

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 DHS' fiscal agent, to collect calendar year 2025 prescription volume attestations from Medicaid-enrolled providers for each of their locations.

Provider participation and timely response are required as the information collected will be used to assign the appropriate professional dispensing fee reimbursement rate in ForwardHealth interChange, DHS' claims processing system, for dates of service (DOS) on and after April 1, 2026. Submit any questions about the attestation survey via email to CODSurvey@mercer.com or call Mercer at 844-294-9982, Monday–Friday, 9 a.m.–5 p.m. Central Time.

Completed surveys must be received no later than Friday, February 6, 2026.

Required Participants
All Wisconsin Medicaid-enrolled providers who dispense covered outpatient drugs are required to participate in the Prescription Volume Attestation Survey. This requirement does not apply to federally qualified health centers or out-of-state providers.

How to Submit Completed Attestation Surveys
Providers can fill out the attestation survey online at https://mercer.qualtrics.com/jfe/form/SV_bd3UK0hgeqJq6y2 or by using the unique provider link included in the Mercer email. Providers can also scan the QR code on the 2026 annual prescription volume survey cover letter dated January 9, 2026. The password for the survey is "WI2026Attestation". Providers may call 844-294-9982 for assistance with the online survey and/or password.

Attestation surveys can be completed using an Excel version of the survey, which may be downloaded from the ForwardHealth Portal at forwardhealth.wi.gov/WIPortal/cms/page/provider/medicaid/pharmacy/apva/resources. Providers may submit the completed survey via one of the following:

- Email to CODSurvey@mercer.com
- Fax to 212-948-0047, Attn: Kerri Wade

Providers may request that a paper copy of the survey be faxed to them by emailing CODSurvey@mercer.com or calling the Mercer survey hotline at 844-294-9982. Providers may submit the completed paper survey via the above email address or fax number.

Completed surveys must be received no later than **Friday, February 6, 2026**. Providers who have not submitted the survey by this date will be assigned the lowest professional dispensing fee reimbursement rate offered by ForwardHealth.

Attesting for Multiple Locations
Providers who have multiple locations must attest for each location individually. The Excel version of the survey enables providers to submit a single survey document for multiple locations. Complete all tabs of the Excel file for a complete submission.

SECTION I – FINANCIAL INFORMATION
The purpose of the Financial Information section is to report calendar year 2025 annual prescription volume that ForwardHealth will use to assign the appropriate professional dispensing fee reimbursement rate for DOS on and after April 1, 2026.

Element 1: Total Annual Prescription Volume
Enter the total number of **all** prescriptions dispensed, not just Medicaid prescriptions, for DOS during the 2025 calendar year. Providers should only report prescription volume for DOS under the current ownership if it is for 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 2025 calendar year.

Wisconsin HIV Drug Assistance Program providers who are not Medicaid-enrolled should enter 0 in this element.

Element 3: Reported Date Range
Enter the 2025 date range for the reported prescription volume if different than January 1, 2025, through December 31, 2025. For changes in ownership during calendar year 2025, enter the date range for the reported prescription volume under the current ownership.

Note: Mercer will use reported data of 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 provider identification.

Element 4: Name – Provider
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
Enter the National Provider Identifier of the Wisconsin Medicaid provider.

Element 7: Address
Enter the street address (including suite, second address, address suite, or mail stop, if applicable), 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: Phone Number
Enter the phone 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: SIGNATURE – Preparer
Enter the signature of the preparer.

Element 12: Date Signed
Enter the date the survey was signed in mm/dd/ccyy format.

Element 13: Name – Preparer
Print or type the preparer's name.

Element 14: Preparer Position / Title
Print or type the preparer's title or position.

Element 15: Preparer Phone Number
Enter the phone number, including area code, where the preparer of this survey may be reached.

Element 16: Preparer Email Address
Enter the email address where the preparer of this survey may be reached.

DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services

PRESCRIPTION VOLUME ATTESTATION SURVEY

INSTRUCTIONS: Refer to the Prescription Volume Attestation Survey Instructions for information about how to access this survey electronically and for instructions on completing and submitting this survey. Providers may call 844-294-9982 for assistance with the survey.

SECTION I – FINANCIAL INFORMATION

1. Total Annual Prescription Volume	2. Total Annual Wisconsin Medicaid Prescription Volume
3. Reported Date Range	

SECTION II – PROVIDER INFORMATION

4. Name – Provider		
5. Wisconsin Medicaid ID Number	6. National Provider Identifier	
7. Address (Street, City, State, and ZIP+4 Code)		
8. Phone Number	9. Email Address	10. Fax Number

SECTION III – CERTIFICATION

By my signature below, I hereby attest that the information submitted in the survey herein is complete and accurate to the best of my knowledge. I understand that any payments made due to incorrect information submitted in this survey may be recouped. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of a primary contractor's contract with the Wisconsin Department of Health Services.

11. **SIGNATURE – Preparer**	12. Date Signed (MM/DD/CCYY)
13. Name – Preparer	
14. Preparer Position / Title	
15. Preparer Phone Number	
16. Preparer Email Address	