

## 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 Gainwell Technologies, to collect calendar year 2022 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, 2023. Submit any questions about the attestation survey via email to [CODSurvey@mercer.com](mailto:CODSurvey@mercer.com) or call Mercer at 844-294-9982, Monday through Friday between 9 a.m. and 5 p.m. Central time.

**Completed surveys must be received no later than January 31, 2023.**

### 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 Attestation Surveys

Attestation surveys may be completed online at [https://mercer.qualtrics.com/jfe/form/SV\\_7af0qpGKiSqZzpA](https://mercer.qualtrics.com/jfe/form/SV_7af0qpGKiSqZzpA) or by using the individual provider link included in the Mercer email. Providers can also scan the QR code on the 2023 annual prescription volume survey cover letter dated January 9, 2023. The password for the survey is "CY2022WIAttestation!". Providers may call 844-294-9982 for assistance with the online survey and/or password.

Attestation surveys may be completed using a Microsoft Excel version of the survey, which may be downloaded from the ForwardHealth Portal at <https://www.forwardhealth.wi.gov/WIPortal/content/provider/medicaid/pharmacy/apva/index.htm.spage>. Providers may submit the completed survey via one of the following:

- Email to [CODSurvey@mercer.com](mailto: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](mailto: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 **January 31, 2023**. 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. 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 2022 annual prescription volume that ForwardHealth will use to assign the appropriate professional dispensing fee reimbursement rate for DOS on and after April 1, 2023.

### Element 1: Total Annual Prescription Volume

Enter the total number of **all** prescriptions dispensed, not just Medicaid prescriptions, for DOS during the 2022 calendar year. Providers should 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 2022 calendar year.

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

**Element 3: Reported Date Range**

Enter the 2022 date range for the reported prescription volume if different than January 1, 2022, through December 31, 2022. For changes in ownership during calendar year 2022, 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 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 (for the Word version only)**

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

**Element 16: Preparer Email Address (for the Word version only)**

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

## 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.

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### SECTION I – FINANCIAL INFORMATION

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

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### SECTION II – PROVIDER INFORMATION

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|--|---------------------------------|--|
| 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 |
|-----------------|------------------|----------------|

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### SECTION III – CERTIFICATION

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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.

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|---------------------------------|------------------------------|
| 11. <b>SIGNATURE</b> – Preparer | 12. Date Signed (MM/DD/CCYY) |
|---------------------------------|------------------------------|

- 
13. Name – Preparer

- 
14. Preparer Position / Title

- 
15. Preparer Phone Number

- 
16. Preparer Email Address
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