

THIS IS YOUR NEW ID CARD. IT IS VALID FOR THE DATES SHOWN.  
SEPARATE IT FROM THE REST OF THE FORM BY TEARING ALONG THE DOTTED LINES.

AGENCY		ELIGIBLE FOR DATES			
ID NUMBER	ELIGIBLE RECIPIENT	BIRTHDATE	SEX	OTHER COVERAGE	
	<p>OUT-OF-STATE NON-EMERGENCY SERVICES REQUIRE PRIOR AUTHORIZATION. YOUR PROVIDER MUST WRITE TO: WISCONSIN MEDICAID OUT-OF-STATE PRIOR AUTHORIZATION STE 88 6406 BRIDGE RD MADISON WI 53784-0088</p>	_____ _____ _____	_____ _____ _____	<p><b>STATE OF WISCONSIN MEDICAID FOSTER CARE PROGRAM TEMPORARY IDENTIFICATION CARD</b></p> <p style="font-size: 1.2em; font-weight: bold;">FXXXXXX    VOID</p>	

EDS FORMS MANAGEMENT    482-006 (REV. 8-95)    SERIAL NO.    WISCONSIN MEDICAID RECIPIENT SERVICES PO BOX 6678 MADISON WI 53716-0678    NOTICE TO PROVIDERS:    NOTICE TO CARDHOLDERS:    FOR QUESTIONS REGARDING: MEDICAID ELIGIBILITY, CALL THE CERTIFYING FOSTER CARE AGENCY. MEDICAID SERVICES COVERAGE, CALL 1-800-362-3002 (TTY AVAILABLE).

VOID