WISCONSIN WELL WOMAN PROGRAM (WWWP)

BREAST AND CERVICAL CANCER SCREENING ACTIVITY REPORT (ARF) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, and address.

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the service.

The use of this form is mandatory when submitting claims for Wisconsin Well Woman Program services.

For reimbursement, mail this form with the completed claim to the following address:

Wisconsin Well Woman Program
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

SECTION I — BILLING PROVIDER INFORMATION

Element 1 — Provider ID
Required. ForwardHealth providers are required to enter a National Provider Identifier (NPI). Non-healthcare providers are required to enter their Provider ID.

Element 2 — Name — Billing Provider
Enter the billing provider's name.

Element 3 — Taxonomy Code
Required. Enter the 10-digit taxonomy code on file with ForwardHealth.

Element 4 — Practice Location ZIP+4 Code
Required. Enter the complete ZIP+4 code associated with the practice service location on file with ForwardHealth.

SECTION II — MEMBER PERSONAL INFORMATION

Element 5 — Last Name — Member
Required. Enter the member's last name.

Element 6 — First Name — Member
Required. Enter the member's first name.

Element 7 — Middle Initial — Member
Not required. Enter the member's middle initial.

Element 8 — Previous Last Name — Member
Not required. Enter the member's previous last name, if applicable.

Element 9 — Member Identification Number
Required. Enter the member ID.

Element 10 — Date of Birth — Member
Required. Enter the member's date of birth in MM/DD/CCYY format.

SECTION III — BREAST AND CERVICAL SCREENING

BREAST SCREENING HISTORY

Element 11 — Previous Mammogram?
Select either "Yes," "No," or "Unknown" to reflect whether or not the member has had a previous mammogram.

Element 12 — Date of Previous Mammogram
If known, provide the date (in MM/DD/CCYY format) on which the member received her most recent mammogram.

Element 13 — Member Reports Breast Symptoms?
Check "Yes," "No," or "Unknown" regarding whether or not the member has reported breast symptoms.

CLINICAL BREAST EXAM

Element 14 — Purpose of CBE
Check whether the member's clinical breast exam (CBE) is a screening or repeat exam.

Element 15 — Date of CBE
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received the CBE.

Element 16 — Name — Rendering Provider
Enter the rendering provider's name.

Element 17 — RESULT
Required if this procedure is performed. Check one box to reflect the results of the CBE. If a shaded result is selected, follow up is required.

MAMMOGRAM

Element 18 — Indication for Initial Mammogram
Check the appropriate box to indicate reason for initial mammogram.

Element 19 — Breast Diagnostic Referral Date
Enter the date (in MM/DD/CCYY format) on which the member received the breast diagnostic referral.

Element 20 — Date of Initial Mammogram
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an initial mammogram.

Element 21 — Name — Rendering Provider
Enter the rendering provider's name.

Element 22 — RESULT
Required if this procedure is performed. Check one box to reflect the results of the mammogram. If a shaded result is selected, follow up is required.

CERVICAL SCREENING HISTORY

Element 23 — Prior Pap Test?
Select either "Yes," or "No" to reflect whether or not the member has had a prior pap test.

Element 24 — Date of Last Pap Test
If Element 23 is marked "Yes," enter the date (in MM/DD/CCYY format) on which the member received her last pap test.

PELVIC EXAM

Element 25 — Date of Pelvic Exam
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a pelvic exam.

Element 26 — Name — Rendering Provider
Enter the rendering provider's name.

Element 27 — RESULT
Required if this procedure is performed. Check one box to reflect the results of the pelvic exam. If shaded result is selected, follow up is required.

PAP TEST

Element 28 — Indication for Pap Test
Check appropriate box to indicate reason for pap test.

Element 29 — Date of Cervical Diagnostic Referral
Enter the date (in MM/DD/CCYY format) on which the member received a cervical diagnostic referral.

Element 30 — Type of Pap Test
Select whether the pap test is liquid based or conventional.

Element 31— Date of Pap Test
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a pap test.

Element 32 — Name — Rendering Provider
Enter the rendering provider's name.

Element 33 — ADEQUACY OF PAP TEST SPECIMEN
Required. Check one box to signify whether the pap test specimen is satisfactory or unsatisfactory.

Element 34 — RESULT
Required if this procedure is performed. Check one box only. If a shaded result is selected, follow up is required.

HPV TEST

The WWWP reimburses a Human Papilloma Virus (HPV) test only as an immediate follow-up to Pap Test results of ASC-US; one year to follow up to LSIL.

Element 35 — Date of HPV Test
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an HPV test.

Element 36 — Result
Required if this procedure is performed. Select the result of the member's HPV test.

BREAST FOLLOW-UP RECOMMENDATION

Element 37 — Recommendation(s)
This element is required when CBE or Mammogram sections are completed. Check all applicable boxes. Include the number of months for "Follow Routine Screening" and "Short-Term Follow up."

CERVICAL FOLLOW-UP RECOMMENDATION

Element 38 — Recommendation(s)
This element is required when the Pelvic Exam, Pap Test, or HPV Test sections are completed. Check all applicable boxes. Include the number of months for "Follow Routine Screening" and "Short-Term Follow up."

Element 39 — NOTES
Include notes, as appropriate.