

**WISCONSIN WELL WOMAN PROGRAM
BREAST CANCER DIAGNOSTIC AND FOLLOW UP REPORT (DRF)
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, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

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, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when submitting claims for ForwardHealth.

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

Required. 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

Enter the member's middle initial.

Element 8 — Previous Last Name — Member

Enter the member's previous last name, if applicable.

Element 9 — Member Identification Number

Required. Enter the member ID.

Element 10 — Date of Birth

Required. Enter the member's date of birth in MM/DD/CCYY format.

SECTION III — BREAST DIAGNOSTIC PROCEDURES

ADDITIONAL MAMMOGRAPHIC VIEWS

Element 11 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a mammogram.

Element 12 — Name — Rendering Provider

Enter the name of the rendering provider.

Element 13 — RESULT

Required if this procedure is performed. Check one box only to reflect results of mammogram. If shaded result is selected, follow up is required.

BREAST CONSULTATION

Element 14 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a breast consultation.

Element 15 — Name — Rendering Provider

Enter the name of the rendering provider.

Element 16 — RESULT / RECOMMENDATION

Required if this procedure is performed. Check one box only to reflect the results of the breast consultation. If shaded result is selected, follow up is required.

BIOPSY

Element 17 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a biopsy.

Element 18 — Name — Rendering Provider

Enter the rendering provider's name.

Element 19 — Biopsy Associated Imaging

Select either "mammogram" or "ultrasound," if applicable.

Element 20 — RESULT

Required if this procedure is performed. Check one box only to reflect results of biopsy. If shaded result is selected, follow up is required.

FILM COMPARISON

Element 21 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a film comparison.

Element 22 — Name — Rendering Provider

Enter the rendering provider's name.

Element 23 — RESULT

Required if this procedure is performed. Check one box only to reflect the results of the film comparison. If shaded result is selected, follow up is required.

FINE NEEDLE ASPIRATION

Element 24 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a fine needle aspiration.

Element 25 — Name — Rendering Provider

Enter the rendering provider's name.

Element 26 — RESULT

Required if this procedure is performed. Check one box only to reflect the results of the fine needle aspiration. If shaded result is selected, follow up is required.

ULTRASOUND

Element 27 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an ultrasound.

Element 28 — Name — Rendering Provider

Enter the rendering provider's name.

Element 29 — RESULT

Required if this procedure is performed. Check one box only to reflect the results of the ultrasound. If shaded result is selected, follow up is required.

Element 30 — NOTES

Enter notes, if applicable.

Element 31 — RECOMMENDATION

This field is required if elements from Additional Mammographic Views, Breast Consultation, Biopsy, Film Comparison, Fine Needle Aspiration, or Ultrasound are completed. Check all applicable boxes.

Element 32 — STATUS OF FINAL DIAGNOSIS

Required. Select one box only to reflect the status of the member's final diagnosis.

Element 33 — FINAL DIAGNOSIS

If "complete" is checked in Element 32, this field is required. Select one box only to reflect the final diagnosis and enter the date in MM/DD/CCYY format.

Element 34 — TUMOR STAGE AND TUMOR SIZE

Check one box to reflect the stage of the member's tumor, if applicable. Enter the size of the member's tumor in centimeters.

Element 35 — TREATMENT STATUS

Check one box only to reflect the member's treatment status.

Element 36 — TREATMENT DATE

Enter date (in MM/DD/CCYY format) as applicable.