WISCONSIN WELL WOMAN PROGRAM
CERVICAL 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 Wisconsin Well Woman Program services.

For reimbursement, mail this completed 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 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 — CERVICAL DIAGNOSTIC PROCEDURES

COLPOSCOPY WITH BIOPSY / ENDOCERVICAL CURETTAGE

Element 11 — Procedure Performed
Check the appropriate box indicating whether a colposcopy with biopsy or an endocervical curettage procedure is performed.

Element 12 — Date Performed
Required if one of these procedures is performed. Enter the date (in MM/DD/CCYY format) on which the member received a colposcopy with biopsy or an endocervical curettage.

Element 13 — Name — Rendering Provider
Enter the rendering provider's name.

Element 14 — RESULT
Required if one of these procedures is performed. Select one box only to reflect the result of the member's colposcopy with biopsy or endocervical curettage. If a shaded result is selected, follow up is required.

LOOP ELECTROSURGICAL EXCISION PROCEDURE (LEEP)

Element 15 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a loop electrosurgical excision procedure (LEEP).

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

Element 17 — RESULT
Required if this procedure is performed. Select one box only to reflect the result of the member's LEEP. If a shaded result is selected, follow up is required.

ENDOMETRIAL BIOPSY

Element 18 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an endometrial biopsy.

Element 19 — Name — Rendering Provider
Enter the rendering provider's name.

Element 20 — RESULT
Required if this procedure is performed. Select one box only to reflect the result of the member's endometrial biopsy. If a shaded result is selected, follow up is required.

COLPOSCOPY WITHOUT BIOPSY

Element 21 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a colposcopy without biopsy.

Element 22 — Name — Rendering Provider
Enter the rendering provider's name.

Element 23 — RESULT
Required if this procedure is performed. Select one box only to reflect the result of the member's colposcopy without biopsy. If a shaded result is selected, follow up is required.

COLD KNIFE CONE

Element 24 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a cold knife cone.

Element 25 — Name — Rendering Provider
Enter the rendering provider's name.

Element 26 — RESULT
Required if this procedure is performed. Select one box only to reflect the result of the member's cold knife cone. If a shaded result is selected, follow up is required.

Element 27 — NOTES
Enter notes, if applicable.

Element 28 — RECOMMENDATION
This element is required if elements under Colposcopy with Biopsy/Endocervical Curettage, Loop Electrosurgical Excision Procedure (LEEP), Endometrial Biopsy, Colposcopy Without Biopsy, and/or Cold Knife Cone are completed. Check all applicable recommendations.

Element 29 — STATUS OF FINAL DIAGNOSIS
Required. Check one box only to reflect the status of the member's final diagnosis.

Element 30 — FINAL DIAGNOSIS
If "Complete" is selected in Element 29, this element is required. Select one box only to reflect the final diagnosis. Enter date in MM/DD/CCYY format.

Element 31 — TUMOR STAGE
Check one box to reflect the member's tumor stage.

Element 32 — TREATMENT STATUS
Check one box only to reflect the member's treatment status.

Element 33 — TREATMENT DATE
Enter date in MM/DD/CCYY format, as applicable.