

Wisconsin Well Woman Program Cervical Cancer Diagnostic and Follow Up Report (DRF) Instructions

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

ForwardHealth members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. Per Wis. Admin. Code § DHS 104.02(4), this information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number.

Under Wis. Stat. 49.45(4), 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).

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 – Client personal information

Element 5: Last name – client

Required. Enter the client's last name.

Element 6: First name – client

Required. Enter the client's first name.

Element 7: Middle initial – client

Enter the client's middle initial.

Element 8: Previous last name – client

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

Element 9: Client ID number

Required. Enter the client ID.

Element 10: Date of birth

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

Section III – Cervical diagnostic procedures

Endocervical Curettage

Element 11: Date performed

Required if these procedures are performed. Enter the date (in MM/DD/CCYY format) on which the client received an endocervical curettage.

Element 12: Name – rendering provider

Enter the rendering provider's name.

Element 13: Result

Required if this procedure is performed. Check one box only to reflect the result of the client's endocervical curettage. If an asterisk result is selected, follow up is required.

Colposcopy Without Biopsy

Element 14: 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 15: Name – rendering provider

Enter the rendering provider's name.

Element 16: Result

Required if this procedure is performed. Check one box only to reflect the result of the client's colposcopy without biopsy. If an asterisk result is selected, follow up is required.

Loop Electrosurgical Excision Procedure (LEEP)

Element 17: Date performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a loop electrosurgical excision procedure (LEEP).

Element 18: Name – rendering provider

Enter the rendering provider's name.

Element 19: Result

Required if this procedure is performed. Check one box only to reflect the result of the client's LEEP. If an asterisk result is selected, follow up is required.

Colposcopy With Biopsy

Element 20: Date performed

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

Element 21: Name – rendering provider

Enter the rendering provider's name.

Element 22: Result

Required if this procedure is performed. Check one box only to reflect the result of the client's colposcopy with biopsy. If an asterisk result is selected, follow up is required.

Cold Knife Cone

Element 23: Date performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the client received a cold knife cone.

Element 24: Name – Rendering provider

Enter the rendering provider's name.

Element 25: Result

Required if this procedure is performed. Check one box only to reflect the result of the client's cold knife cone. If an asterisk result is selected, follow up is required.

Endometrial Biopsy

Element 26: Date performed

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

Element 27: Name – rendering provider

Enter the rendering provider's name.

Element 28: Result

Required if this procedure is performed. Check one box only to reflect the result of the client's endometrial biopsy. If an asterisk result is selected, follow up is required.

Section IV – Recommendations and diagnosis

Element 29: Notes

Enter notes, if applicable.

Element 30: Recommendation

This field is required if elements under Endocervical Curettage, Colposcopy Without Biopsy, Loop Electrosurgical Excision Procedure (LEEP), Colposcopy With Biopsy, Cold Knife Cone, and/or Endometrial Biopsy are completed. Check all applicable recommendations. If checking "Follow Routine Screening Schedule" or "Short Term Follow-up," include the appropriate number of months.

Element 31: Status of final diagnosis

Required. Check one box only to reflect the status of the client's final diagnosis.

Element 32: Final diagnosis

If "Complete" is selected in Element 31, this element is required. Check one box only to reflect the final diagnosis. Enter date in MM/DD/CCYY format. If checking "Other," enter the client's final diagnosis in text box.

Element 33: Tumor stage

This field is required if the Final Diagnosis is Invasive Cervical Cancer or Adenocarcinoma of the Cervix. Check one box to reflect the client's tumor stage.

Element 34: Treatment status

This field is required if the Final Diagnosis is CIN 2/Moderate Dysplasia, CIN 3/Severe Dysplasia/CIS, HSIL (Biopsy Diagnosis), Invasive Cervical Cancer, or Adenocarcinoma of the Cervix. Check one box only to reflect the client's treatment status.

Element 35: Treatment date

This field is required if the Final Diagnosis is CIN 2/Moderate Dysplasia, CIN 3/Severe Dysplasia/CIS, HSIL (Biopsy Diagnosis), Invasive Cervical Cancer, or Adenocarcinoma of the Cervix. Enter the treatment date (in MM/DD/CCYY format) as applicable.