

**WISCONSIN WELL WOMAN PROGRAM (WWWP)**

**Multiple Sclerosis(MS) Report & Referral**

Information and additional instructions on reverse side

<b>A. CLIENT INFORMATION – Must be completed for each form submitted.</b>		
<ul style="list-style-type: none"> <li>Client enrollment must be confirmed before any services can be covered by WWWP (enrollment must be renewed every 12 months).</li> <li>To confirm enrollment, check with the client's WWWP Local Coordinator. The list of Coordinators is available by calling WWWP (608-266-8311) or on the web at: <a href="http://www.dhfs.wisconsin.gov/womenshealth/wwwp">www.dhfs.wisconsin.gov/womenshealth/wwwp</a></li> </ul>		
1. Last Name	2. First Name	3. Maiden Name
4. Social Security Number (Optional) or Client Identification Number:	5. Date of birth (mm/dd/yyyy)	6. Telephone Number
7. Client Enrollment Date (mm/dd/yyyy)	8. County	9. Native American Tribe (give name if applicable)

<b>B. LOCAL COORDINATOR INFORMATION – Case Management for High Risk Client</b>		
To be complete, this Form must include the Client Information, confirmed enrollment, and Coordinator Information.		<ul style="list-style-type: none"> <li>Copy of Form + referral notes → PCP.</li> <li>Copy of Form → WWWP-MS* for reimbursement.</li> </ul>
10. Local Coordinating Agency	11. Coordinator Name	12. Coordinator's telephone number:
13. Case management provided by assisting client with referral for MS services:		
<input type="checkbox"/> Primary Care Provider	Name _____	Date referred _____
<input type="checkbox"/> MS Center	Name _____	Date referred _____
<input type="checkbox"/> NMSS-WI for support services to get to MS Center for diagnosis		Date referred _____
14. "MS Testing: Client Page for WWWP" given to client: <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>C. PRIMARY CARE PROVIDER - Initial MS Assessment</b> (see "MS Assessment: Services & Rates for WWWP")	
To be complete, this Form must include the Client Information, confirmed enrollment in WWWP, and Primary Care Provider Information.	
<ul style="list-style-type: none"> <li>Copy of Form + referral notes → MS Center.</li> <li>Copy of Form + claim → WWWP-MS*</li> <li>Copy of Form → Local Coordinator if client assistance needed.</li> </ul>	
15. Provider/Clinic Name (print)	16. Provider/Clinic City (print)
17. Beginning Multiple Sclerosis assessment date (mm/dd/yyyy)	18. Performing Provider (print)
19. Findings of beginning MS Assessment (check all that apply)	
<input type="checkbox"/> Within normal limits	<input type="checkbox"/> High risk signs of multiple sclerosis
<input type="checkbox"/> Signs of some other condition (not MS)	<input type="checkbox"/> Previous diagnosis of MS and needs help with MS treatment
20. Referred to participating MS Center (check one) <input type="checkbox"/> Marshfield Clinic MS Center <input type="checkbox"/> UW Hospital & Clinic MS Center	
Additional Centers may participate in the future.	
21. "MS Testing: Client Page for WWWP" given to client: <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Referred to Local WWWP Coordinator for assistance getting to MS Center for testing: <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>D. MS CENTER - MS Diagnostic Testing</b> (see "MS Assessment: Services & Rates for WWWP")	
To be complete, this Form must include the Client Information, referring PCP Information, and MS Center Information.	
<ul style="list-style-type: none"> <li>Copy of Form + clinical notes → referring PCP.</li> <li>Copy of Form + clinical notes + claim → WWWP-MS*.</li> </ul>	
23. MS Center name (print)	24. Performing Provider name (print)
25. Initial MS Consultation Date (mm/dd/yyyy)	26. Final Diagnosis Date (mm/dd/yyyy)
27. Final diagnosis (check all that apply)	
<input type="checkbox"/> MS confirmed	<input type="checkbox"/> Other health condition (non-MS)
<input type="checkbox"/> MS suspected, not confirmed	<input type="checkbox"/> Within normal limits
28. Recommended follow-up after Final Diagnosis (check all that apply)	
<input type="checkbox"/> MS treatment	29. MS Treatment Status after Final Diagnosis (check one only)
<input type="checkbox"/> Additional MS testing in future if another MS episode	
<input type="checkbox"/> Follow-up for other health condition (non-MS diagnosis or treatment)	
<input type="checkbox"/> No follow-up needed at this time	
	<input type="checkbox"/> MS - treatment started and date ____/____/____ (mm) (dd) (yyyy)
	<input type="checkbox"/> MS - treatment refused <input type="checkbox"/> MS - lost to follow-up

\* **SUBMITTING CLAIMS FOR REIMBURSEMENT:** Providers must submit the claim for services and a completed copy of this MS Report & Referral Form (and clinical notes when indicated) in order to be reimbursed. Submit claims and Forms to: WWWP-MS, WI Division of Public Health, P.O. Box 2659, Madison, WI 53701.

## **INFORMATION AND ADDITIONAL INSTRUCTIONS WWWP Multiple Sclerosis (MS) Report & Referral**

**INFORMATION:****AUTHORITY & USE:**

The Department of Health and Family Services - Wisconsin Well Woman Program (WWWP) has the authority to collect personally identifiable information necessary to determine eligibility for services for the WWWP. The personally identifiable information collected on this form will ONLY be used to determine eligibility for services and reimbursement for providers for covered services.

**PRIVACY:**

The Wisconsin Well Woman Program and its participating providers must be HIPAA compliant. This includes protecting the privacy of medical information for clients served by WWWP. The WWWP web site has more information on HIPAA procedures for providers for WWWP:

<http://dhfs.wisconsin.gov/womenshealth/wwwp/>

**INSTRUCTIONS:**

At this time, this Form can only be completed and submitted as a "hard copy". Please print clearly. For additional copies of this Form, blank copies of this Form can be photocopied, or additional copies are available from WWWP at:

Phone: 608-266-8311

Web: <http://dhfs.wisconsin.gov/womenshealth/wwwp/>

**SOCIAL SECURITY NUMBER OR CLIENT IDENTIFICATION NUMBER FOR WWWP:**

The client's social security number is optional and will only be used to determine eligibility for WWWP services and eligibility for other health care programs. Clients who do not have or do not provide a social security number, will be assigned a WWWP Client Identification Number by the Local WWWP Coordinator for their county/tribe of residence.

**LOCAL COORDINATOR LIST FOR WWWP:**

To contact a client's WWWP Local Coordinator, to confirm the client's enrollment or to help with referrals related to MS services, a list of Local Coordinators for WWWP is available from WWWP at:

Phone: 608-266-8311

Web: <http://dhfs.wisconsin.gov/womenshealth/wwwp/>

**"MS ASSESSMENT: SERVICES & RATES FOR WWWP":**

The current list of WWWP-covered services and reimbursement rates for MS services, and the "MS Staged Assessment Tool for WWWP Providers" are available from WWWP at:

Phone: 608-266-8311

Web: <http://dhfs.wisconsin.gov/womenshealth/wwwp/>

**MS CENTERS PARTICIPATING IN WWWP STAGED ASSESSMENT FOR MS:**

The current list of MS Centers, which are participating in the WWWP staged assessment and providing MS diagnostic testing, is available from WWWP at:

Phone: 608-266-8311

Web: <http://dhfs.wisconsin.gov/womenshealth/wwwp/>

**SUBMITTING REQUIRED COPIES OF FORM:**

After providers complete their necessary sections of this Form, the completed Form should be photocopied to share with the specified parties (e.g., referral providers, WWWP, Local Coordinator).

**SUBMITTING CLAIMS FOR REIMBURSEMENT:**

Providers must submit the claim and a copy of the completed MS Report & Referral Form in order to be reimbursed for WWWP MS services. At this time, only hard copies of claims and MS Forms can be accepted. Submit claims for MS services and MS Report & Referral Forms to:

WWWP-MS

WI Division of Public Health

P.O. Box 2659

Madison, WI 53701.