BadgerCare Plus

Face-to-Face (F2F) Encounter

Documentation of an F2F encounter is REQUIRED for patients to qualify for select Medicaid Services

PRESCRIPTION FOR SERVICES (FOR MEDICAID PATIENTS ONLY)

Qualified Physician & Non Physician Practitioner: Please complete the information below with the required patient information.

Patients name (*print*): ______________________________

Patients DOB: ______________________________

Encounter Date: ______________________________

***** Encounter date is the initial date when the physician or qualified non-physician practitioner performed the qualifying F2F encounter with the patient. *****

Check the services that will be ordered:

Service		ICD 10	
Home Health:	____________	ICD 10:	____________
DME:	____________	ICD 10:	____________
DMS:	____________	ICD 10:	____________
PT:	____________	ICD 10:	____________
ST:	____________	ICD 10:	____________
OT:	____________	ICD 10:	____________

***** Submit clinical documentation to support the initial F2F date *****

I Certify that the above information is true and correct based on my encounter with this patient. If I am not the community based physician, then I am certifying the need for services based on my contact with the patient.

Signature (MD, NP, PA or CNS): ______________________________

Name: (*printed*): ______________________________

Date: ______________________________

Please fax completed form to: 414-771-1159

For Questions please contact My Choice Wisconsin Health Plan Medical Management at: 414-755-3619 (Select Option 4 then Option 1)

CONFIDENTIALITY NOTE: This form contains privileged and confidential information intended only for the use of the addressee. If you are not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that reading it is strictly prohibited. If you have received this information in error, please immediately return it to the sender and delete it from your system. Thank you.