DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10099 (07/08)

STATE OF WISCONSIN

NOTICE OF STATE AUTHORIZED PLACEMENT OF A MEDICAID RECIPIENT IN AN OUT-OF-STATE TREATMENT FACILITY

TO:

Medicaid Certifying Agency Name / Address

The Division of Health Care Financing has authorized the placement of the Medicaid recipient named below in the named out-of-state treatment facility for medical treatment unavailable in Wisconsin. In accordance with the Medicaid Eligibility Handbook, Chapter 3.1.8, the recipient is considered a resident of Wisconsin for as long as the placement is authorized. The recipient has been advised to apply or reapply as necessary for Medicaid eligibility at your agency. If current case information is not on file, please send an appropriate application to the recipient at the facility mailing address below. If no responsible party is identified, the facility will notify you of the recipient's new address when this recipient is discharged and returned to Wisconsin.

MEDICAID RECIPIENT INFORMATION

Name	Medicaid Number

Mailing Address on Medicaid File (Street, City, State, Zip Code)

PARTY RESPONSIBLE FOR SIGNING MEDICAID APPLICATION

Name	Telephone Number (Including Area Code)
	( )

Address (Street, City, State, Zip Code)

MEDICAL FACILITY

Name

Address (Street, City, State, Zip Code)

Medical Facility Contact Person	Telephone Number (Including Area Code)
	( )

PERIOD OF AUTHORIZED PLACEMENT (Subject to Renewal)

Begin Date	End Date

PLACEMENT AUTHORIZED BY

SIGNATURE	Date Authorized	Telephone Number (Including Area Code)
		( )

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