

 <b>WRAPAROUND MILWAUKEE Policy &amp; Procedure</b>	Date Issued: <b>7/31/02</b>	Reviewed: <b>11/19/09</b> By: <b>JM</b> Last Revision: <b>11/19/09</b>	Section: <b>PROVIDER NETWORK</b>	Policy No: <b>041</b>	Pages: <b>1 of 4</b> (5 Attachments)
	<input checked="" type="checkbox"/> Wraparound <input checked="" type="checkbox"/> Wraparound/REACH <input checked="" type="checkbox"/> FISS	Effective Date: <b>1/1/10</b>	Subject: <b>OUT-OF-NETWORK VENDOR PLAN FOR SHORT-TERM SERVICES</b>		

## I. POLICY

It is the policy of Wraparound Milwaukee to allow enrollees access to Behavioral Health and other select services where the Covered Service cannot be obtained from an In-Network provider.

“**Covered Services**” refer to services that Vendors in the Wraparound Milwaukee Provider Network are authorized to provide to Enrollees/Service Recipients. Covered Services are authorized and paid for based on conditions set forth in the Wraparound Milwaukee/Vendor Fee-for-Service Agreement and Wraparound Milwaukee program specific policies and procedures. Each Covered Service has a definition, credentialing requirement(s), National Identification Code, Wraparound Milwaukee Service Code and Wraparound Milwaukee established rate of reimbursement. All Vendor Agencies and Direct Services Providers must be approved to provide services through the Provider Network Application process or the Out-of-Network Vendor authorization process before providing services to Wraparound Milwaukee Enrollees and their families. Reimbursement for authorized Covered Services is made at the Wraparound Milwaukee approved rate in effect at the time the Covered Service was provided.

## II. PROCEDURE

### A. General Guidelines.

1. Services provided by Out-of-Network Vendors are limited to the enrolled youth and must be authorized by the Wraparound Milwaukee Provider Network in advance of the service delivery.
2. Authorizations for Out-of-Network services are appropriate under the following circumstances:
  - a. When the Enrollee is placed outside the Milwaukee Metropolitan Area and will need Behavioral Health or Substance Abuse Services.
  - b. When the Direct Service Provider offers a professionally recognized “specialty” and there are NO Practitioners in the Wraparound Milwaukee Provider Network with the identified specialty that offers the same service.
  - c. For payment of a Group Home placement where the enrolled youth was placed in the group home facility by the Bureau of Milwaukee Child Welfare prior to enrollment in Wraparound Milwaukee.
  - d. For REACH enrolled youth where the youth has been receiving services from a Behavioral Health provider prior to enrollment. The Out-of-Network authorization is limited to a period of up to 90 days to allow for one of the following:
    - To allow the Vendor to complete services.
    - To allow the Vendor to apply to join the Wraparound Milwaukee Provider Network.
    - To allow Vendor transition of services to an In-Network Vendor.
3. Authorizations for Out-of-Network services are limited to the following Covered Services:
  - a. M.D. Assessment.
  - b. Medication Management (with or without therapy).

- c. Individual/Family Therapy & Counseling – Office Based.
  - d. Individual/Family Therapy & Counseling-PhD – Office Based.
  - e. Psychological Evaluation Services-PhD.
  - f. Psychological Evaluation - Extended-PhD (requires prior authorization from Dr. Morano).
  - g. AODA Assessment.
  - h. AODA Individual/Family Counseling.
  - i. Group Home/Group Home Specialized (where the youth was placed in a facility by the Bureau of Milwaukee Child Welfare prior to enrollment in Wraparound Milwaukee).
4. Authorizations are enrollee specific. The length of the authorizations will vary based on the Covered Services being authorized and the specific enrollee/youth's needs.
  5. Out-of-Network services may be authorized for a Vendor in the process of applying for permanent Vendor status.

**B. Care Coordinator Responsibilities.**

The Care Coordinator is responsible for completion of the “OUT-OF-NETWORK VENDOR REQUEST” form (*see Attachment 1*) and submitting it to the Wraparound Milwaukee Provider Network for approval. The Vendor should **not** complete the form.

1. Prior to submitting the “OUT-OF-NETWORK VENDOR REQUEST” form, the Care Coordinator should contact the Vendor to confirm that the Vendor: 1) currently provides the requested Wraparound Milwaukee Covered Service(s); 2) is accepting new clients; and 3) is willing to enter into a time-limited agreement with Wraparound Milwaukee.
2. The Care Coordinator should submit a completed “OUT-OF-NETWORK VENDOR REQUEST” form to the Wraparound Milwaukee Provider Network as soon as the Care Coordinator becomes aware of the need for Covered Services from a Vendor that is not enrolled in the Wraparound Milwaukee Provider Network.
  - a. Enter ALL required information on the form - incomplete forms will not be processed. Identify the Wraparound Milwaukee Covered Service(s) being requested including: 1) the Wraparound Milwaukee service code; 2) the service name; 3) the reimbursement rate; and 4) the full name of Vendor Agency Direct Service Provider. Multiple services and providers from the same agency can be identified on the same form.
  - b. Obtain the Care Coordinator Supervisor's signature.
  - c. Attach a copy of the Wraparound referral form(s) for the requested service(s).
  - d. Submit the completed form(s) to the attention of the Wraparound Milwaukee Provider Network via fax at (414) 257-7575.
3. Authorizations are approved effective the first day of the month that the Request is approved by the Provider Network. Authorizations cannot be backdated.
4. When the Out-of-Network Vendor Request is approved, the initial SAR authorization is entered into Synthesis (Wraparound Milwaukee's Information Management and Billing System) by Wraparound Milwaukee Provider Network staff. Thereafter, the Care Coordinator is responsible for ongoing monthly service authorizations using the “Turnaround SAR” feature in Synthesis. The Care Coordinator can end the service authorization by NOT renewing the service on the Turnaround SAR. (Note that failure to authorize the approved Out-of-Network service on the Turnaround SAR will automatically end the authorization,

requiring the Care Coordinator to submit a paper service authorization request to the Wraparound Milwaukee Finance Department).

5. The Care Coordinator should obtain the approval of the Child and Family Team for the Out-of-Network service at the next schedule Child and Family Team Meeting and include the approved Out-of-Network service specific interventions on the enrollee/youth's Plan of Care.

**C. Provider Network Responsibilities.**

1. Upon receipt of an OUT-OF-NETWORK VENDOR REQUEST form, the Provider Network Support Specialist reviews the Request for completeness and obtains any additional required documentation from the Vendor. This process can take up to two or more weeks, depending upon the timeliness of the Vendor's response.
2. The Provider Network Coordinator approves or denies the Out-of-Network Request based on the Care Coordinator's justification for the service, a review of service availability within the Provider Network and the identified Vendor's/Direct Service Providers credential confirmation and response to the referral.
3. If the request is denied, a letter of explanation is sent to the Care Coordinator and a "NOTICE OF ACTION" form (*see Attachment 2*) is completed and sent to the enrollee's parent or guardian (copy to the Care Coordinator) explaining the reason for the denial.
4. If the request is approved, a TIME-LIMITED AGREEMENT TO PROVIDE SERVICES" form (*see Attachment 3*) identifying the term of the agreement, Vendor approved Covered Service(s), Direct Service Provider(s) and reimbursement rate is processed with the Vendor.
5. Once the signed Vendor Agreement is received and approved by the Wraparound Milwaukee Provider Network, all relevant Vendor related information is entered into Synthesis.
6. A "CONFIRMATION LETTER" (*see Attachments 4a and 4b*) is sent to the Vendor along with a copy of the Executed Time-Limited Agreement and Vendor billing instructions. The Care Coordinator and Wraparound Finance Director will receive a copy of the confirmation letter.
7. The initial Service Authorization Request (SAR) is entered into Synthesis by Wraparound Milwaukee Provider Network Staff based on the information contained in the Request. All subsequent SAR entries are the responsibility of the Care Coordinator.

**D. Vendor Responsibilities.**

1. The Vendor must agree to the Terms of the Client Specific Time-Limited Wraparound Milwaukee Agreement.
2. The Vendor is responsible for maintaining current Agency and Direct Service Provider Credentials and Licenses.
3. The Vendor must sign the Milwaukee County Caregiver Resolution Certification Statement.
4. The Vendor must maintain Agency Progress Records related to provision of the Covered Service.
5. The Vendor must submit invoices in accordance with Wraparound Milwaukee's invoicing procedures.
6. The Vendor must maintain ongoing communication with the service recipient's Care Coordinator, providing ongoing progress reports as needed.

**E. Billing Procedure.**

Unless otherwise permitted per Wraparound Milwaukee Policy and Procedure, the Vendor may invoice Wraparound Milwaukee for Covered Services beginning the 1<sup>st</sup> of each month following the month in which the Covered Service was provided. The Vendor may invoice Wraparound Milwaukee electronically using Synthesis, or in writing using the Wraparound Milwaukee Invoice

Form, a HCFA 1500 form or UB92 form. Invoices must contain the Enrollee/Service Recipient's name, the name of the Direct Service Provider, the name of the Covered Service provided, a record of units of service provided by date, unit cost, and total cost per Service Recipient. Group Home Vendors must use Synthesis to enter Progress Reports and process Vendor invoicing. Synthesis access and training is provided to the Vendor following execution of the Time-Limited Service Agreement. Vendor invoices must be submitted within 60 days of the last day of the month in which the service was provided.

**F. Authorization Extension Procedure.**

1. The initial Out-of-Network Vendor Authorization generally ranges from 3 to 6 months.
2. The Care Coordinator can request an extension of the Out-of-Network Vendor Authorization if continued services are justified and identified on the enrollee's Plan of Care. The Care Coordinator submits an "OUT-OF-NETWORK VENDOR AUTHORIZATION EXTENSION" form (*see Attachment 5*) to the Provider Network at least 2 weeks prior to the expiration of the current authorization.
3. The Care Coordinator should submit a completed OUT-OF-NETWORK VENDOR AUTHORIZATION EXTENSION form to the Wraparound Milwaukee Provider Network
  - a. Enter ALL required information on the form - incomplete forms will not be processed.
  - b. Obtain the Care Coordinator Supervisor's signature.
  - c. Submit the completed form(s) to the attention of the Wraparound Milwaukee Provider Network via fax at (414) 257-7575.
4. The OUT-OF-NETWORK VENDOR AUTHORIZATION EXTENSION is reviewed by the Wraparound Milwaukee Provider Network Coordinator for continued service need and approved or denied. Services that have not been incorporated into the Enrollee's Plan of Care will not be extended.
5. If the request is denied, a letter of explanation is sent to the Care Coordinator and a "Notice of Action" form (*see Attachment 2*) is completed and sent to the enrollee's parent or guardian (copy to the Care Coordinator) explaining the reason for the denial.
6. If the Request is approved, the Extension Request is faxed to the Vendor, with a copy to the Care Coordinator, and the Vendor Agreement Extension is entered into Synthesis to reflect the extension date.

**G. Disenrollment Procedure.**

The client specific Time-Limited Vendor Agreement ends when the last day of the service agreement has been reached or sooner if the Care Coordinator or Care Coordinator Supervisor notifies the Wraparound Milwaukee Provider Network in writing or via email that the service is no longer needed. Failure to maintain continuous service authorizations using the Turnaround SAR in Synthesis will result in non-renewal of the client service authorization for the following month.

Reviewed & Approved by: Bruce Kamradt  
Bruce Kamradt, Director

**NOTE:**  
 Authorizations are generally limited to the enrolled youth.

WRAPAROUND MILWAUKEE  
**OUT OF NETWORK VENDOR  
 REQUEST FORM**



COMPLETE A SEPARATE FORM FOR EACH OUT-OF-NETWORK AGENCY WORKING WITH THE YOUTH  
**ATTACH A COPY OF THE WRAPAROUND REFERRAL FORM FOR THE REQUESTED SERVICES**

**INCOMPLETE REQUESTS AND REQUESTS THAT ARE MORE THAN 30 DAYS OLD WILL NOT BE PROCESSED.**

Care Coordinator Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Care Coordinator Agency: \_\_\_\_\_

Client Name: \_\_\_\_\_  Wraparound  REACH (**check program**)

Anticipated First Date of Service: \_\_\_\_\_ Anticipated Last Date of Service: \_\_\_\_\_

(Approvals are limited to a maximum of 6 months and can be renewed if needed.)

Reason for Request: \_\_\_\_\_

Approved by Child/Family Team?  Yes  No Included in POC?  Yes  No Date of POC: \_\_\_\_\_

**AGENCY INFORMATION**

Agency Name: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ FAX: \_\_\_\_\_

**SERVICES / DIRECT SERVICE PROVIDER(S)**

Service Code	# of First Month Units	Service Name	Rate	Provider Name

Submitted By:

\_\_\_\_\_  
 Care Coordinator Signature

\_\_\_\_\_  
 Date

Supervisor Review/Approval:

\_\_\_\_\_  
 Care Coordinator Supervisor Signature

\_\_\_\_\_  
 Date

**PROVIDER NETWORK PROCESSING**

Out-of-Network Requests are processed within 48 hours of receipt. Following administrative approval and verification of Provider credentials/licensing. Timeframe for Out-of-Network Agency compliance with this requirement varies. **Care Coordinator and Provider will be notified of the outcome of the request.**

**PROVIDER NETWORK ACTION**

PENDING  APPROVED  DENIED

**COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Approved By:

Provider Network Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return completed form to Theresa Randall, Wraparound Milwaukee – Provider Network – FAX 414-257-7575  
 9201 Watertown Plank Road, Milwaukee, WI. 53226 / Telephone Number 414-257-8108**



## Notice of Action



**Enrollee Name:**

Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Relationship:**

**RE:**

Dear ,

Please be advised that the request to authorize [ENTER SERVICE] services provided to [ENTER YOUTH NAME] at [ENTER AGENCY] has been [ENTER ACTION]. [INSERT REASON].

Please work with your Care Coordinator to obtain another provider for the requested services for [ENTER YOUTH NAME].

**Action Taken:**

Denied  Reduced  Terminated  Suspended  Limited

If you have any questions call Pamela Erdman, Wraparound Quality Assurance Director at (414) 257-7608.

If you do not agree with this decision, please see the attached process to appeal.

**Interpreter Services:**

English – For help to translate or understand this, please call your Care Coordinator.

Spanish – Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono Su Coordinador de Cuidado.

Hmong – Yog xav tau kev pab txhais cov ntaub ntauv no kom koj totaub, hu rau Koj saib xyaus Kevnab

Russian – Если вам не всё понятно в этом документе, позвоните по телефону Ваш Координатор заботы!

Sincerely,

Jeannine P. Maher  
Provider Network Coordinator

cc: Pamela Erdman – Director, Quality Assurance  
Janet Friedman – Administrator, Finance  
(Care Coordinator)

If you do not agree with this decision you have the right to:

1. Look at the information Wraparound used to make its decision.
2. File a grievance with Wraparound **within 45 days** of the date of this letter if you disagree with the decision.
  - a. If you were not receiving the service before this decision Wraparound Milwaukee does not have to provide or pay for the service while you grieve.
  - b. If Wraparound Milwaukee authorized and paid for the service before this decision, Wraparound Milwaukee must continue to provide the same level of service while you grieve, but if our decision does not change you may have to pay for the services you received while you were grieving.
3. Request that your grievance be handled in an urgent manner, i.e. – within 2 working days, if the decision could result in illness or injury or if the delay in services could effect the enrollees health.
4. Meet in person with Wraparound Administration to present more information about your grievance.
5. Bring a friend, family member or representative with you to the meeting.
6. Have an interpreter at the meeting if needed, free of charge.
7. Have the right to appeal to the State of Wisconsin Department of Health Services (DHS) if you do not agree with our decision.

 To file a grievance with Wraparound Milwaukee, call the Wraparound Quality Assurance Dept. at **(414) 257-7608**



**If you want to appeal to DHS you can call the BadgerCare Plus Ombuds at 1-800 760-0001.**

8. You also have the right to appeal to the State of Wisconsin Division of Hearings and Appeals (DHA) for a Fair Hearing. You must send an appeal **within 45 days** of the date of this letter if you disagree with the decision. If you appeal this action to DHA before the effective date, the service may continue. You may need to pay for the cost of services if the hearing decision is not in your favor.



**If you want a Fair Hearing, send a written request to:**

Department of Administration  
Division of Hearings and Appeals  
P.O. Box 7875  
Madison, WI 53707-7875



**If you need help writing a request for a Fair Hearing, please call the:**

BadgerCare Plus Ombuds at (800) 760-0001  
**OR**  
Wraparound Milwaukee Quality Assurance  
Department at (414) 257-7608

**WRAPAROUND MILWAUKEE  
TIME-LIMITED AGREEMENT TO PROVIDE SERVICES  
OUT OF NETWORK PROVIDER**

**AGREEMENT ENTERED INTO BY AND BETWEEN**

Milwaukee County Department of Human Services (hereinafter referred to as “Wraparound Milwaukee”) and **[ENTER CLINIC NAME]** hereinafter referred to as “Out of Network Provider”) on this **[ENTER TODAY’S DAY]** day of **[ENTER MONTH, YEAR]**, to provide services to **[ENTER YOUTH NAME]** from **[ENTER FIRST DATE OF SERVICE]** to **[ENTER LAST DATE OF SERVICE]** (“term”). **This authorization has been approved for the above timeframe subject to compliance with the requirements of Wraparound Milwaukee Group Home prior authorization with this youth.**

**Out of Network Provider agrees to the following:**

1. This Agreement is specific to the above-named client for services as set forth Provider in this agreement for a period of time not to exceed the term as set forth above, unless an extension is approved by the Wraparound Milwaukee Provider Network Coordinator.
2. Out of Network Provider agrees to comply with the Wisconsin Caregiver Law and Milwaukee County’s Care Giver Resolution Requiring Background Checks on Department of Human Services Contract Agency Employees Providing Direct Care and Services to Children and Youth (copies enclosed).
3. Out of Network Provider agrees to indemnify and hold harmless Milwaukee County officers, employees, from and against all loss or expense including costs and attorney’s fees by reason of liability for damages including suites at law or in equity, caused by any wrongful, intentional, or negligent act or omission of the Out of Network Provider, or its agents which may arise out of or are connected with the activities covered by this agreement.
4. Out of Network Provider agrees to maintain insurance coverage as follows for the term of this agreement:

**Wisconsin Worker’s Compensation**

Statutory Limits

**General Liability and/or Excess Umbrella Liability Insurance (Minimum)**

\$1,000,000 - Per Occurrence

\$1,000,000 – General Aggregate

**Professional Liability (Required for all Mental Health and AODA Providers - Minimum)**

\$1,000,000 - Per Occurrence

\$3,000,000 – Annual Aggregate

**Automobile Liability (Required only for Agencies Transporting Clients -Minimum)**

\$1,000,000 - Per Accident

Uninsured Motorist

5. Failure to abide by these terms may result in non-payment of services.
6. Out of Network Provider agrees to comply with all policies and procedures related to documentation of services provided as a condition for billing for said service, and to manual billing made to Wraparound Milwaukee using the Wraparound Milwaukee Invoice (enclosed), HCFA-1500 form or UB92 form not later than 60 days from the date of service. **For group homes, a monthly Progress Report must be before payment can be processed if the agency will be billing for more than 14 days of care for the calendar month.**
7. The Out of Network Provider shall maintain such records and financial statements as required by state and Federal laws, rules, and regulations. The Out of Network Provider shall retain all documentation necessary to adequately demonstrate the date, time, duration, location, intervention, summary of the activity engaged in and Participant’s response to the covered service provided,

unless indicated otherwise in the service description, Provider Bulletin, or Policy and Procedure. Wraparound Milwaukee reserves the right not to pay for units of services reported by the Out of Network Provider that are not supported by documentation required under this agreement.

8. Funds agreed to under this Out of Network Provider Time-Limited Agreement are intended to be the "payor of last resort" after all other public and private funds restricted to the services being purchased, including medical insurance and restricted contributions, have been exhausted. Payments for services covered by this Agreement shall be made in accordance with the "order of payment" requirements for the funding agency/funding program, and other collections made by the Out of Network Provider for services covered by this Agreement. Under no circumstances shall the Out of Network Provider bill, charge, seek remuneration or compensation from or have recourse against the participant, or any person acting on his/her behalf, for covered Services provided under this Agreement.
9. No funds within this Agreement may be used to supplant Health Insurance, other Health Maintenance Organizations, or Preferred Provider Organization funded services.
10. Any changes that impact on availability of funding shall be sufficient cause for the County to immediately reduce the amount of payment or unit rate paid to the Out of Network Provider with or without advance notice.
11. Out of Network Provider agrees not to substitute another Direct Service Provider for the Direct Service Provider identified in the Referral, without prior authorization from the Wraparound Provider Network Coordinator. Requests to change the Direct Services Provider are to be made in writing to the Wraparound Milwaukee Provider Network Coordinator.
12. Wraparound Milwaukee reserves the right to audit client files at any time without advance notice. Wraparound Milwaukee further reserves the right to recoup monies related to audit disallowances.
13. Either party may cancel said agreement at any time with or without just cause except Group Home Providers who agree to provide Wraparound Milwaukee with 30 days notice of cancellation of this agreement.

**OUT OF NETWORK PROVIDER AGREES TO PROVIDE THE FOLLOWING SERVICE(S) AT THE IDENTIFIED RATE FOR THE TERM OF THIS AGREEMENT AND ANY AGREEMENT EXTENSIONS.**

<b>Service Code</b>	<b>Service</b>	<b>Direct Service Provider</b>	<b>Rate</b>	<b>Unit</b>
<b>CPT &amp; WRAP</b>				

**FOR MILWAUKEE COUNTY**

\_\_\_\_\_  
 Bruce J. Kamradt  
 Director, Wraparound Milwaukee Program

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Jeannine P. Maher  
 Wraparound Provider Network Coordinator

\_\_\_\_\_  
 Date

**FOR OUT OF NETWORK PROVIDER**

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Title



MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION  
**WRAPAROUND MILWAUKEE**

Phone: (414) 257-7611

9201 Watertown Plank Road, Wauwatosa, WI 53226

Fax: (414) 257-7575

**ENTER TODAY'S DATE]**

**[ENTER CONTACT NAME]  
 [ENTER NAME/ADDRESS OF CLINIC]**

**Re: [ENTER CLIENT NAME]**

Dear **[ENTER CONTACT NAME]:**

This letter will confirm your agency's approval to provide the following services to the above youth:

Service Code	Service	Service Provider	Rate	Term
<b>CPT &amp; WRAP</b>				

Enclosed are a case specific invoice form, Certification Statement-Resolution Requiring Background Checks, and an executed copy of the Time-Limited Agreement between Wraparound Milwaukee (Milwaukee County) and **[enter agency name]**.

This letter is your confirmation that the service(s) identified above are approved so that you can bill Wraparound Milwaukee for services rendered. Please bill at the end of the month using the enclosed invoice form. As this is a case-specific authorization, you may not provide services to any other child in our program without written approval. Invoices will not be accepted after 60 days from the last date of service. Please follow the enclosed billing procedure. If you have any questions regarding it, please contact Janet Friedman at (414) 257-7597, and let her know you are an Out-of-Network vendor.

In terms of documentation, it will be necessary for you to keep detailed notes on the care of the client, as the Wraparound Program reserves the right to spot audit your program at any time should the need arise.

Thank you for participating in the Wraparound Milwaukee system of care. If you have any questions, please contact me at (414) 257-7835.

Sincerely,

Jeannine P. Maher  
 Wraparound Provider Network Coordinator

cc: **[CARE COORDINATOR, AGENCY NAME]**  
 Janet Friedman, Wraparound Finance



ATTACHMENT 4B - GROUP HOME LETTER  
 MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION  
**WRAPAROUND MILWAUKEE**

Phone: (414) 257-7611

9201 Watertown Plank Road, Wauwatosa, WI 53226

Fax: (414) 257-7575

**[ENTER TODAY'S DATE]**

**[ENTER CONTACT NAME]**

**[ENTER NAME/ADDRESS OF CLINIC]**

**Re: [ENTER CLIENT NAME]**

Dear **[ENTER CONTACT NAME]**:

This letter will confirm your agency's approval to provide the following services to the above youth:

Service Code	Service	Provider	Rate	Term
<b>CPT &amp; WRAP</b>				

**This authorization has been approved for the above timeframe subject to compliance with the requirements of Wraparound Milwaukee Group Home prior authorization with this youth.**

Enclosed are a Certification Statement – Resolution Requiring Background Checks and an executed copy of the Time-Limited Agreement between Milwaukee County and **ENTER AGENCY NAME**.

**Please note that a monthly Progress Report must be submitted before payment can be processed if your agency will be billing for more than 14 days of care for the calendar month.**

This letter is your confirmation that the service(s) identified above are approved so that you can bill Wraparound Milwaukee for services rendered. Please bill at the end of the month using the enclosed invoice form. As this is a case-specific authorization, you may not provide services to any other child in our program without written approval. Invoices will not be accepted after 60 days from the last date of service. Please follow the enclosed billing procedure. If you have any questions regarding it, please contact Janet Friedman at (414) 257-7597, and let her know you are an Out-of-Network vendor.

In terms of documentation, it will be necessary for you to keep detailed notes on the care of the client, as the Wraparound Program reserves the right to spot audit your program at any time should the need arise.

Thank you for participating in the Wraparound Milwaukee system of care. If you have any questions, please contact me at (414) 257-7835.

Sincerely,

Jeannine P. Maher  
 Wraparound Provider Network Coordinator

cc: **[CARE COORDINATOR, AGENCY NAME]**  
 Janet Friedman, Wraparound Finance  
 Cheryl Peterson, Wraparound Milwaukee

**NOTE:**  
Authorizations are generally limited to the enrolled youth.

WRAPAROUND MILWAUKEE  
**OUT OF NETWORK VENDOR  
AUTHORIZATION EXTENSION FORM**



ATTACHMENT 5

**FORM MUST BE COMPLETED/SUBMITTED WITHIN 14 DAYS OF CURRENT AUTHORIZATION END DATE**

Care Coordinator Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Care Coordinator Agency: \_\_\_\_\_

Client Name: \_\_\_\_\_  Wraparound  REACH (*check program*)

End Date of Current Authorization: \_\_\_\_\_ Proposed End Date of Service: \_\_\_\_\_

Reason for Extension: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Approved by Child/Family Team?  Yes  No Included in POC?  Yes  No Date of POC \_\_\_\_\_

**AGENCY INFORMATION**

Agency Name: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ FAX: \_\_\_\_\_

**SERVICES / DIRECT SERVICE PROVIDER**

Service Code	Service Name	Rate	Provider Name

Submitted By:

\_\_\_\_\_  
Care Coordinator Signature

\_\_\_\_\_  
Date

Supervisor Review/Approval:

\_\_\_\_\_  
Care Coordinator Supervisor Signature

\_\_\_\_\_  
Date

**PROVIDER NETWORK PROCESSING**

Out-of-Network Referrals are processed within 48 hours of receipt. **Care Coordinator and Provider will be notified of the outcome of the extension request.**

**PROVIDER NETWORK ACTION**

PENDING  APPROVED  DENIED

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

Approved By:

Provider Network Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return completed form to Theresa Randall, Wraparound Milwaukee – Provider Network – FAX 414-257-7575  
9201 Watertown Plank Road, Milwaukee, WI. 53226 / Telephone Number 414-257-8108**