

 WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 7/31/02	Reviewed: 12/13/10 By: JM Last Revision: 12/13/10	Section: PROVIDER NETWORK	Policy No: 041	Pages: 1 of 4 (5 Attachments)
☒ Wraparound ☒ Wraparound-REACH ☒ FISS ☒ Project O-Yeah	Effective Date: 1/1/11	Subject: OUT-OF-NETWORK SERVICES			

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 [Agencies](#) 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 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 [Wraparound Provider Network](#) 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 [Enrollee](#) 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 or substance abuse counselor](#) 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 [Direct Service Provider](#) to complete services.
 - To allow the [Agency/Direct Service Provider](#) to apply to join the Wraparound Milwaukee Provider Network.
 - To allow [Direct Service Provider](#) transition of services to an In-Network [service provider](#).
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.
 - d. Individual/Family Therapy & Counseling-Licensed Psychologist – Office.
 - 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 [Enrollee's](#) needs.
- 5. Out-of-Network services may be authorized for a [Provider that is](#) in the process of applying for [In-Network](#) 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 [Direct Service Provider](#) should **not** complete the form.

- 1. Prior to submitting the “OUT-OF-NETWORK VENDOR REQUEST” form, the Care Coordinator should contact the [Provider](#) to confirm that the [Direct Service Provider](#): 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 [Provider](#) 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 [Out-of-Network](#) 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 [Service](#) 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. [Once this occurs](#), the Care Coordinator [will need](#) to submit a paper service authorization request to the Wraparound Milwaukee Finance Department [in order to authorize the service](#)).
- 5. The Care Coordinator should obtain the approval of the Child and Family Team for the Out-of-Network service at the next scheduled Child and Family Team Meeting and include the approved Out-of-Network service specific interventions on the [Enrollee’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 [Out-of-Network Provider](#). This process can take up to two or more weeks, depending upon the timeliness of the [Out-of-Network Provider’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 Direct Service Provider's 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, [Out-of-Network Provider Agency](#) approved Covered Service(s), Direct Service Provider(s) and reimbursement rate is processed with the [Out-of-Network Provider](#).
5. Once the signed [Time-Limited](#) Agreement is received and approved by the Wraparound Milwaukee Provider Network, all relevant [Out-of-Network Provider](#) related information is entered into Synthesis.
6. A "CONFIRMATION LETTER" (*see Attachments 4a and 4b*) is sent to the [Out-of-Network Provider](#) along with a copy of the Executed Time-Limited Agreement and [Provider](#) 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. [Out-of-Network Provider](#) Responsibilities.

1. The [Out-of-Network Provider](#) must agree to the Terms of the [Enrollee](#) specific Time-Limited Wraparound Milwaukee Agreement.
2. The [Out-of-Network Provider](#) is responsible for maintaining current Agency and Direct Service Provider Credentials and Licenses.
3. The [Out-of-Network Provider](#) must sign the Milwaukee County Caregiver Resolution Certification Statement.
4. The [Out-of-Network Provider](#) must maintain Agency Progress Records related to provision of the Covered Service [and Enrollee's response to services](#).
5. The [Out-of-Network Provider](#) must submit invoices in accordance with Wraparound Milwaukee's invoicing procedures.
6. The [Out-of-Network Provider](#) must maintain ongoing communication with the [Enrollee's](#) Care Coordinator, providing ongoing progress reports as needed.

E. Billing Procedure.

Unless otherwise permitted per Wraparound Milwaukee Policy and Procedure, the [Out-of-Network Provider](#) may invoice Wraparound Milwaukee for Covered Services beginning the 1st of each month following the month in which the Covered Service was provided. The [Out-of-Network Provider](#) 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 Homes must use Synthesis to enter Progress Reports and process [Out-of-Network Provider](#) invoicing. Synthesis access and training is provided to the [Out-of-Network Provider](#) following execution of the Time-Limited Service Agreement. [Out-of-Network Provider](#) 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 [Service](#) Authorization generally ranges from 3 to 6 months.
2. The Care Coordinator can request an extension of the Out-of-Network [Service](#) Authorization if continued services are justified and identified on the enrollee's Plan of Care. The Care Coordinator submits an "OUT-OF-NETWORK [SERVICE](#) AUTHORIZATION EXTENSION" form (*see Attachment 5*) to the Provider Network at least 2 weeks prior to the expiration of the current authorization.

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Out-of-Network Services Policy

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3. The Care Coordinator should submit a completed OUT-OF-NETWORK [SERVICE 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 [SERVICE AUTHROIZATION 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 [Out-of Network Provider](#), with a copy to the Care Coordinator, and the [Service 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,

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.)

Justification for Use of Out of Network Provider/Agency: _____

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



WRAPAROUND MILWAUKEE

Phone: (414) 257-7611

9501 Watertown Plank Rd., Milw., WI 53226

Fax: (414) 257-7575

Notice of Action

Purpose:

To notify Wraparound enrollees if a service is denied, reduced, terminated, discontinued, suspended or limited.

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 ntawv no kom koj totaub, hu rau Koj saib xyaus Kevpab

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”).

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, HCFA-1500 form or UB92 form not later than 60 days from the date of service.
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.

Service Code	Service	Direct Service Provider	Rate	Unit
CPT & WRAP				

FOR MILWAUKEE COUNTY

 Bruce J. Kamradt
 Director, Wraparound Milwaukee Program

 Date

 Jeannine P. Maher
 Wraparound Provider Network Coordinator

 Date

FOR OUT OF NETWORK PROVIDER

 Print Name

 Date

 Title

 Signature



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
CPT & WRAP				

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



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
CPT & WRAP				

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 entered in Synthesis 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. 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. 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
Diane Thompson, Wraparound Milwaukee

NOTE:
Authorizations are generally
limited to the enrolled youth.

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



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