MILWAUKEE COUNTY
WRAPAROUND MILWAUKEE

Director – Bruce Kamradt

ENROLLMENT REQUEST

Medicaid Member ID Number _____

Participant Name _____ _____ _____
(Last) (First) (M.I.)

Date of Birth: _____ Enrollment Start Date: _____

By signing below, I indicate that I wish to participate in the Wraparound Milwaukee (WAM) program and voluntarily enroll myself in the program. The ways that this affects my health care coverage are listed below and were explained to me:

If I currently have Title 19 coverage, I understand that I will be enrolled in the Wraparound Milwaukee HMO program through T19, which will be responsible for payment for all of my behavioral health and alcohol- and drug-related services. I am aware that if I am currently seeing any behavioral health providers who are not part of the Wraparound Milwaukee network, I will need to switch to providers who are part of the Wraparound Milwaukee network.

If I am currently in a Title 19 HMO for health care, I understand that my coverage for **physical health care will now be provided through straight Title 19** (also called fee-for-service). I am aware that my current physical health care providers may not accept straight Title 19 insurance; in those instances, I will need to switch to a new physical health care provider during my enrollment in Wraparound Milwaukee.

If I have private insurance coverage, that carrier will remain the primary insurer for both physical and behavioral health care. As a secondary payor source, Wraparound Milwaukee will pay for any behavioral health and alcohol- and drug-related services that are part of my Plan of Care which are not covered by my private insurance. If a placement in a group home, residential care or foster care occurs, I will become eligible for Title 19 during that placement, but my private health insurance will remain the primary insurer.

If I have no insurance, my care coordinator will work with me to see if I qualify for any type of Medicaid or Title 19 services. If I do qualify, I will be enrolled in the Wraparound Milwaukee HMO for behavioral and drug- and alcohol-related services, and in straight Title 19 for physical health services. If I do not qualify, Wraparound Milwaukee will pay for any behavioral or drug- and alcohol-related services that are part of my Plan of Care.

_____ _____ _____ _____
Enrollee's signature (if age 18 or older) | Date | Legal guardian's signature (if enrollee under age 18) | Date

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FOR EDS USE:
Enrollment is: APPROVED / DENIED
(circle one)

If denied, reason: _____

Effective start date: _____

County of residence listed for recipient: _____

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