ROSTER BILLING FORM COMPLETION INSTRUCTIONS
REIMBURSEMENT FOR TREATMENT AND VACCINATION OF THE UNINSURED

The Roster Billing Form allows providers to receive both (1) the $15 vaccine administration fee to administer the H1N1 vaccine to asymptomatic uninsured individuals and (2) the $48 bundled treatment fee to provide initial ambulatory evaluation and treatment to symptomatic uninsured individuals who present with influenza-like illness.

Complete a separate Roster Billing Form for each service delivery site.

A check for services billed on the Roster Billing Form will be sent to the "Check Address" of the service delivery site indicated by the Participating Provider on Attachment 1 of the Memorandum of Agreement.

Submit the completed Roster Billing Form to the Department either electronically or on paper. The Department strongly encourages electronic submission to facilitate processing.

Follow these steps to submit the Roster Billing Form electronically:

- Complete and save a separate Roster Billing Form for each service delivery site.
- Create a Zip file of all completed Roster Billing Forms that the Participating Provider would like to submit. For HIPAA compliance reasons, encrypt and password protect the Zip file. For the password, use the 10-digit phone number of one of the Participating Provider's service delivery sites. Be sure to use the phone number for the service delivery site as it was indicated by the Participating Provider on Attachment 1 of the Memorandum of Agreement. Do not include any spaces, hyphens, or special characters in the password (e.g., 6085551234). For step-by-step instructions on encrypting and password-protecting electronic files, please see the document titled "Encryption Instructions" available through http://pandemic.wisconsin.gov/.
- Attach the encrypted Zip file to an email; indicate "H1N1 Flu Roster Billing Form" in the subject line of the email. Please note: the Department's email system can only accept emails up to 15MB in size.
- In the body of the email, include the Participating Provider's name and the name and address of the service delivery site whose phone number was used as the password for the encrypted Zip file. Also include the contact information, including a phone number, of the individual sending the email.
- Send the email to DHSuninsured@dhs.wisconsin.gov.

For paper submission, print and complete the form. Participating Providers may submit multiple paper forms together if multiple forms are required to identify all uninsured individuals who received vaccination or treatment at the service delivery site. Header information should be completed on each form.
Mail the completed form(s) to the following address:

Division of Health Care Access and Accountability
1 W. Wilson St, Rm 472
Madison, WI 53701
ATTN: Paul Michael

SECTION I —PROVIDER INFORMATION

Element 1 — Name — Participating Provider
Enter the name of the Participating Provider who signed the Memorandum of Agreement with the Department (e.g., "___ Health Systems").

Element 2 — Name and Address — Service Delivery Site
Enter the name and address of the service delivery site (e.g., "___ North Clinic"). The minimum requirement is the name, street, city, state, and ZIP+4 code. The names of rendering providers (e.g., Dr. Doe) do not need to be identified on the form.

Element 3 — Telephone Number — Service Delivery Site
Enter the telephone number, including area code, of the service delivery site.

Element 4 — National Provider Identifier—Service Delivery Site (if available)
Enter the NPI of the service delivery site, if available.

Element 5 — Invoice Number
Optional—Participating Providers may enter an internal invoice number, up to 12 alphanumeric characters, in this space. This number will appear on documentation sent along with the check for services billed on the Roster Billing Form.

SECTION II — ROSTER OF RENDERED SERVICES

Please note: If filling out the Form electronically, providers can insert additional rows into the Roster of Rendered Services to accommodate additional patients.

Elements 6-8
List the name of each patient (first name, last name, and middle initial) who received vaccination or treatment on a separate row in the roster.

Element 9 — Rate Type
Indicate "**V**" to receive the $15 vaccine administration fee for asymptomatic uninsured patients who received only the H1N1 vaccine and no additional evaluation and treatment. Indicate "**T**" to receive the $48 treatment fee for symptomatic patients presenting with influenza-like illness for whom initial evaluation and treatment was provided.

Element 10 — Date of Birth
Enter the patient's date of birth in MM/DD/CCYY format (e.g., February 3, 1955, would be 02/03/1955).

Element 11 — Address — Patient (if available)
Enter the complete address of the patient's place of residence, if known.

Element 12 — Social Security Number (if available)
Enter the patient's Social Security number, if known. Do not include hyphens.

Element 13 — Date of Service
Enter the date the patient was vaccinated or treated in MM/DD/CCYY format.

Element 14 — Antiviral Information
If antiviral medication from state or federal stockpiles was distributed during the visit, enter the dosage of the antiviral medication and the Lot Number of the antiviral medications. Leave this field blank if antiviral medications from the state or federal stockpile were not distributed to the patient.

SECTION III — ATTESTATION OF UNINSURANCE

Element 15 — Signature — Authorized Agent of the Participating Provider
Sign the statement indicating that the Participating Provider, to the best of his or her knowledge, only listed patients on the Roster Billing Form who, on the date of service, were uninsured.

For paper submission, sign this field. For electronic submission, type the Participating Provider's name in this field.

Element 16 — Date Signed
Enter the date on which the Authorized Agent of the Participating Provider signed the form.