

# Treatment Funds Request

Every Woman Matters



NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

4/2022

In order for your client to access Medicaid or other treatment resources this form must be completed. The following documents are required to initiate the process for financial assistance. Please write in the dates below when the forms/report were sent.

<b>Treatment Funds Request Form:</b>	Date Sent: ____/____/____
<b>Breast/Cervical Diagnostic Enrollment, Follow Up and Treatment Plan:</b>	Date Sent: ____/____/____
<b>Pathology Report:</b>	Date Sent: ____/____/____

For more information see the Women's and Men's Health Program Provider Participation Manual.

## Client Information

<b>First Name</b>		<b>Middle Initial</b>	<b>Last Name</b>		<b>Maiden Name</b>	
<b>Birthdate</b> ____/____/____		<b>Social Security #</b>		<b>Home/Cell Phone</b> <small>circle one</small> ( )		<b>Work Phone</b> ( )
<b>Address</b>			<b>City</b>	<b>County</b>	<b>State</b>	<b>Zip</b>
<b>In what state was the client born:</b> _____			<b>Primary Language?</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____			
<b>Is the client a U.S. Citizen?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<i>(Please attach a copy of the client's INS papers, if available)</i>			
If no, what is the client's immigration status? _____						
<b>Eligibility:</b> Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No Private Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, list name of insurance company: _____			<b>Diagnostic Test:</b> _____ Diagnostic Test Date: ____/____/____ Result: <input type="checkbox"/> CIN II <input type="checkbox"/> CIN III <input type="checkbox"/> Cancer in situ (breast or cervical) <input type="checkbox"/> Invasive cancer (breast or cervical)			
			<b>Treatment:</b> _____ Scheduled Date: ____/____/____ Performed Date: ____/____/____			

Nebraska Medicaid notifies all clients of acceptance to Medicaid Treatment.

<b>SURGEON/CLINIC:</b> _____	Phone: (____) _____
Contact Person: _____	Fax: (____) _____

<b>Referred By/Clinic:</b> _____	Phone: (____) _____
Contact Person: _____	Fax: (____) _____

Completed by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

See other side for Points of Importance.

## ***Points of Importance***

- The Treatment Funds Request Form must be completed, for all clients accessing Nebraska Medicaid. The completion of this form begins the process of obtaining treatment through Medicaid.
- Clients must be enrolled and diagnosed with breast or cervical precancer or cancer in the Every Woman Matters program and a pathology report confirming diagnosis must be submitted.
- Clients must complete and submit the Breast and Cervical Cancer Medicaid Supplement Form initiated by EWM staff.
- EWM Clinical Staff may work with providers and clients to complete the required forms as needed.
- For EWM and Medicaid, if the client is a US Citizen, no further verification is needed. However, if the client is **NOT** a US Citizen proof of permanent residency is required by way of a front/back copy of their permanent resident card or other documentation if they don't have a card.
- Clients who receive Medicaid for cervical dysplasia are eligible for Medicaid for 60 days.
- Clients treated for cervical dysplasia most likely will not receive a Medicaid **card** due to the short time frame they are on Medicaid.
- Clients who receive Medicaid for breast or cervical cancer cannot be older than 64 years of age.
- Clients receiving Medicaid for breast cancer or invasive cervical cancer are eligible for Medicaid for six (6) months. Medicaid may extend this period if the client is still receiving treatment for breast cancer. **The provider will need to submit a letter to Medicaid for an extension.**
- Nebraska Medicaid issues Medicaid numbers. Every Woman Matters does not issue them.
- To retrieve or verify a client's Medicaid number call **1-800-642-6092**.
- If applicable, Nebraska Medicaid notifies all clients of acceptance to Medicaid Treatment funds along with a copy of Client Rights and Responsibilities.
- Clients ineligible for Nebraska Medicaid may be reviewed for eligibility for other treatment dollars.

Nebraska Department of Health and Human Services  
Women's and Men's Health Programs, Every Woman Matters  
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Fax: .402.471.0913  
E-mail: [dhhs.EWM@nebraska.gov](mailto:dhhs.EWM@nebraska.gov)  
Website: [www.dhhs.ne.gov/womenshealth](http://www.dhhs.ne.gov/womenshealth)

Reasonable accommodations made for persons with disabilities. TDD (800) 833-7352. The Nebraska Department of Health and Human Services provides language assistance at no cost to limited English proficient persons who seek our services.

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