

Treatment Funds Request Form

Version: September 2014

Every Woman Matters

Department of Health & Human Services



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

Treatment Funds Request Form completed by provider on:	Date ____/____/____	EWM Use Only <input type="checkbox"/> Yes/received
Breast/Cervical Diagnostic Enrollment, Follow Up and Treatment Plan completed by provider on:	Date ____/____/____	
Pathology Report sent on:	Date ____/____/____	

For more information see Page 37 of the EWM Program Provider Contract Manual.

Client Information

First Name		Middle Initial	Last Name		Maiden Name
Birthdate		Social Security #		Home/Cell Phone <i>circle one</i> ()	Work Phone ()
Address			City	County	State Zip
In what state was the client born:			Primary Language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other		
Is the client a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what is the client's immigration status? _____ <i>(Please attach a copy of the client's INS papers, if available)</i>					
Eligibility: 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: _____			Diagnostic Test: _____ 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)		
			Treatment: _____ Scheduled Date: ____/____/____ Performed Date: ____/____/____		

Nebraska Medicaid notifies all clients of acceptance to Medicaid Treatment.

SURGEON/CLINIC: _____ Contact Person: _____	Phone: (____) _____ Fax: (____) _____
HOSPITAL: _____ Contact Person: _____	Phone: (____) _____ Fax: (____) _____
PATHOLOGY: _____ Contact Person: _____	Phone: (____) _____ Fax: (____) _____
ANESTHESIOLOGY: _____ Contact Person: _____	Phone: (____) _____ Fax: (____) _____
Referred By/Clinic: _____ Contact Person: _____	Phone: (____) _____ Fax: (____) _____

Attach claim(s) to this form and submit to EWM Staff at the Central Office in Lincoln for clients NOT eligible for Medicaid. Providers have 60 days to submit claims for processing to the EWM Foundation. Treatment funds, if available, are administered through the EWM Foundation.

See reverse of this form for Points of Importance

Points of Importance

- **Federal law now requires that all clients applying for Medicaid Treatment must send a copy of their driver's license or photo ID. If the client was not born in Nebraska they need to send a copy of their birth certificate also. If the client was not born in the United States the client will need to send a copy of their Naturalization papers, Citizenship papers, or Permanent Resident Card. Please do not send the original.**
- The Treatment Funds Request Form must be completed, for all clients accessing Nebraska Medicaid or the Every Woman Matters Foundation, in order to receive treatment funds. Every Woman Matters (EWM) staff begins the process to evaluate the client for treatment funding options when the Treatment Funds Request Form is received.
- Clients must complete and submit the Breast and Cervical Cancer Medicaid Supplement Form initiated by EWM staff.
- EWM Case Managers may work with providers and clients to complete the required forms as needed.
- Clients receiving Medicaid for cervical dysplasia are eligible for Medicaid for 60 days.
- Clients treated for cervical dysplasia most likely will not receive a Medicaid **card**.
- Clients receiving 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.
- 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 will be reviewed for eligibility for other treatment dollars.
- Every Woman Matters Foundation funds are limited to \$250 (cervical) / \$500 (breast) per client, per diagnosis, per lifetime, as long as funds are available.
- Client Photo ID (Birth Certificate if client born outside of Nebraska) and Pathology Report required PRIOR to submission to EWM.

Nebraska Department of Health and Human Services
Women's and Men's Health Programs, Every Woman Matters
301 Centennial Mall South, P.O. Box 94817
Lincoln, NE 68509-4817
1-800-532-2227
Fax: (402) 471-0913
E-mail: dhhs.ewm@nebraska.gov
Website: 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.

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services. #5U58/DP000811-05, #5U58/DP001421-04 and #5U58/DP002043-03