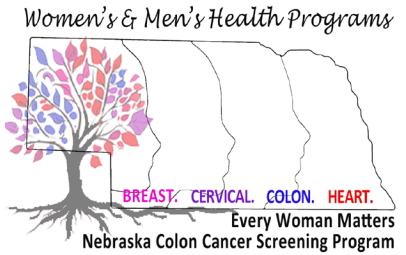
OTHER IMPORTANT EWM FORMS

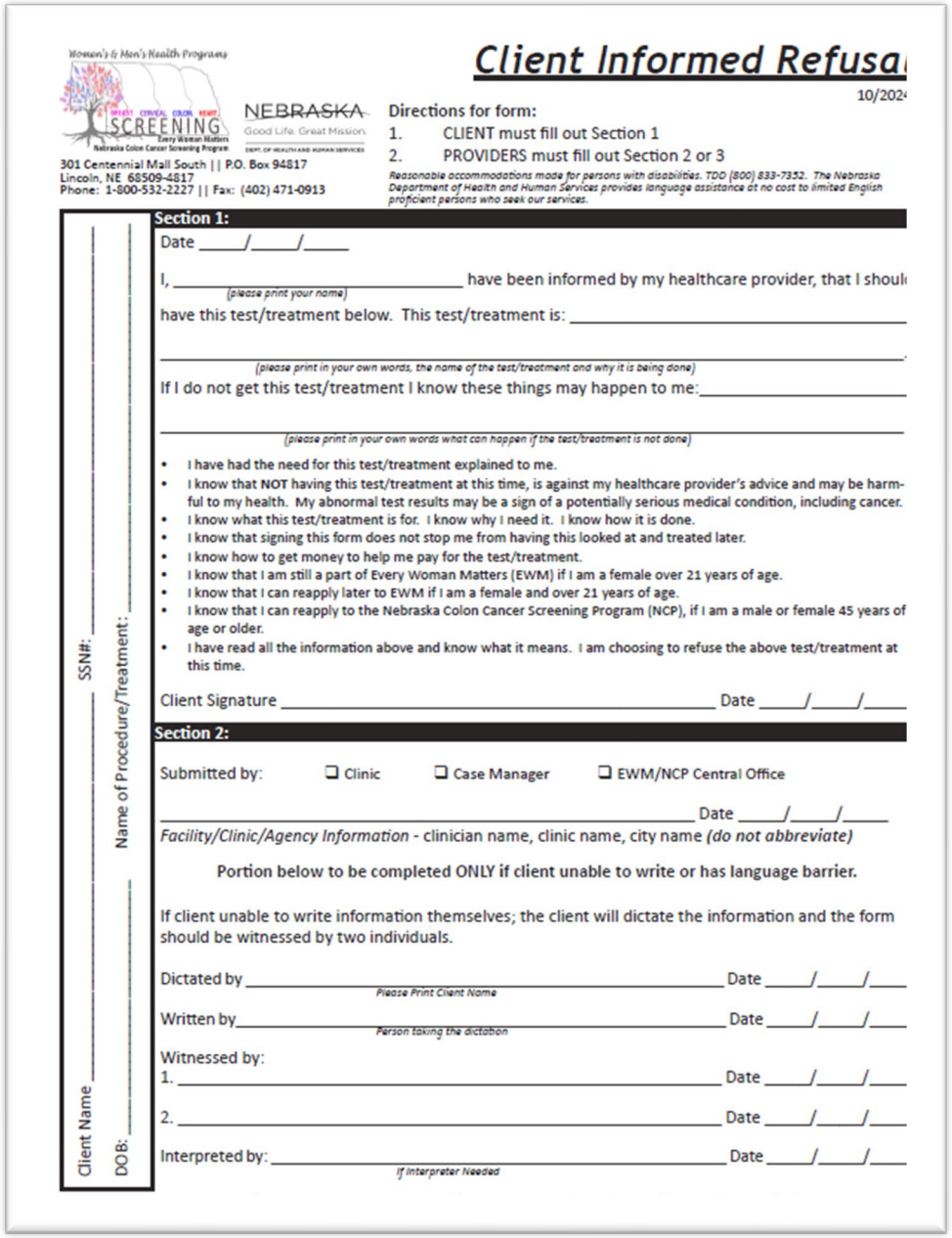
EVERY WOMAN MATTERS

Client Informed Refusal & Service Provider Documentation Form



Client Informed Refusal

- If client refuses diagnostic services or diagnostic treatment services, the provider should complete the Client Informed Refusal form.
- The provider should ensure that the client has enough information to make an informed decision. The form should be given to the client in person or mailed. If mailed, information should be given by phone.
- The client has 30 days to return the form to the provider.



Women's & Men's Health Programs

SCREENING

NEBRASKA
Good Life. Great Mission.

301 Centennial Mall South || P.O. Box 94817
Lincoln, NE 68509-4817
Phone: 1-800-532-2227 || Fax: (402) 471-0913

Client Informed Refusa

10/202

Directions for form:
1. CLIENT must fill out Section 1
2. PROVIDERS must fill out Section 2 or 3

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.

SSN#: _____ Name of Procedure/Treatment: _____

Client Name _____ DOB: _____

Section 1:

Date ____/____/____

I, _____ have been informed by my healthcare provider, that I shoul
(please print your name)

have this test/treatment below. This test/treatment is: _____

_____.
(please print in your own words, the name of the test/treatment and why it is being done)

If I do not get this test/treatment I know these things may happen to me:_____

_____
(please print in your own words what can happen if the test/treatment is not done)

- I have had the need for this test/treatment explained to me.
- I know that **NOT** having this test/treatment at this time, is against my healthcare provider's advice and may be harmful to my health. My abnormal test results may be a sign of a potentially serious medical condition, including cancer.
- I know what this test/treatment is for. I know why I need it. I know how it is done.
- I know that signing this form does not stop me from having this looked at and treated later.
- I know how to get money to help me pay for the test/treatment.
- I know that I am still a part of Every Woman Matters (EWM) if I am a female over 21 years of age.
- I know that I can reapply later to EWM if I am a female and over 21 years of age.
- I know that I can reapply to the Nebraska Colon Cancer Screening Program (NCP), if I am a male or female 45 years of age or older.
- I have read all the information above and know what it means. I am choosing to refuse the above test/treatment at this time.

Client Signature _____ Date ____/____/____

Section 2:

Submitted by: ❑ Clinic ❑ Case Manager ❑ EWM/NCP Central Office

_____ Date ____/____/____

Facility/Clinic/Agency Information - clinician name, clinic name, city name *(do not abbreviate)*

Portion below to be completed ONLY if client unable to write or has language barrier.

If client unable to write information themselves; the client will dictate the information and the form should be witnessed by two individuals.

Dictated by _____ Date ____/____/____
Please Print Client Name

Written by_____ Date ____/____/____
Person taking the dictation

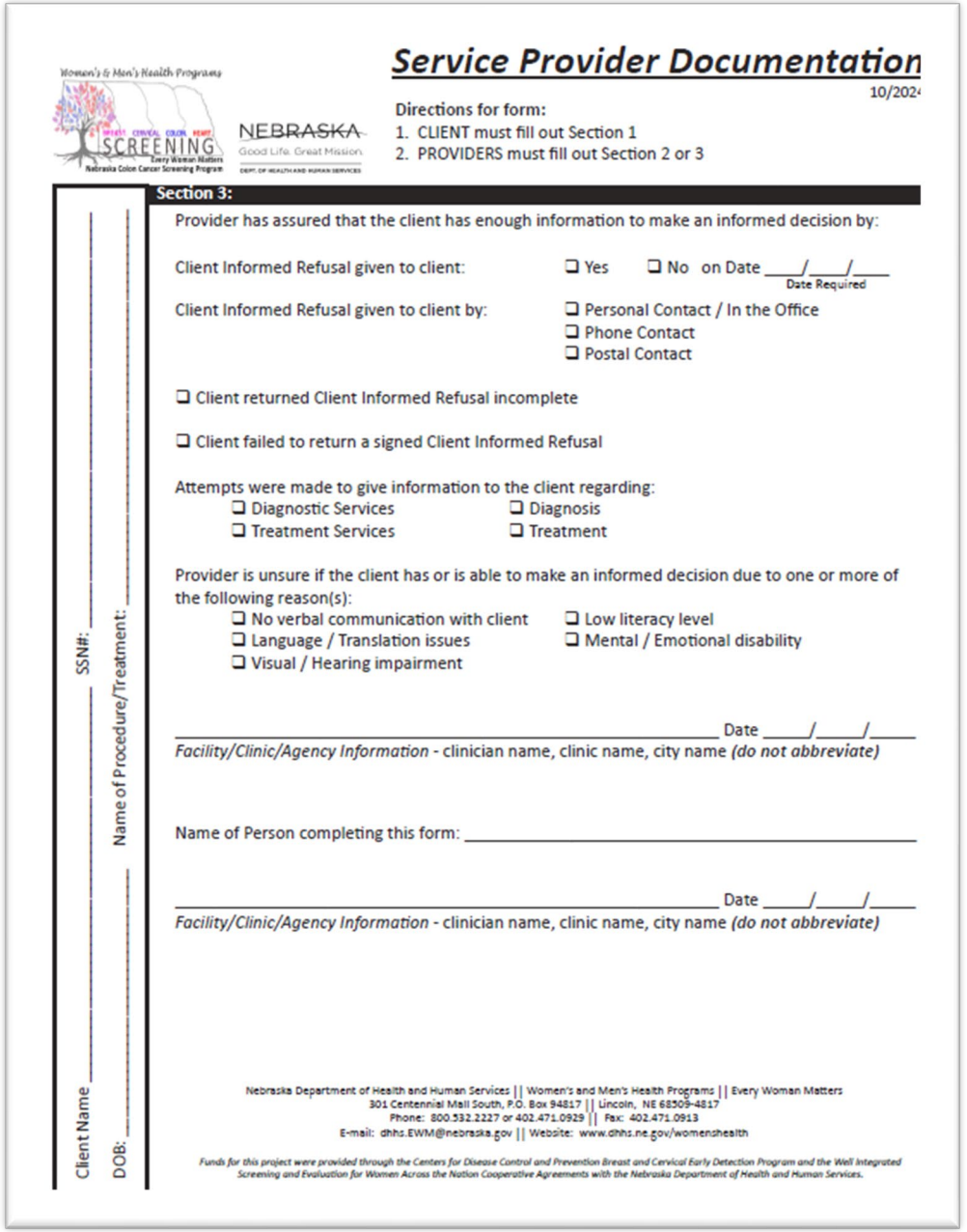
Witnessed by:
1. _____ Date ____/____/____

2. _____ Date ____/____/____

Interpreted by:_____ Date ____/____/____
If Interpreter Needed

Service Provider Documentation

- The client has 30 days to return the Client Informed Refusal form to the provider.
- If client fails to return or sign the Client Informed Refusal, the provider should complete a Service Provider Documentation form.
- Filling out this form indicates whether or not the provider believes the client had enough information to make an informed decision.



Women's & Men's Health Programs

SCREENING

Nebraska Colon Cancer Screening Program

NEBRASKA
Good Life. Great Mission.

Service Provider Documentation

10/202

Directions for form:
1. CLIENT must fill out Section 1
2. PROVIDERS must fill out Section 2 or 3

Client Name _____ DOB: _____ SSN#: _____ Name of Procedure/Treatment: _____

Section 3:

Provider has assured that the client has enough information to make an informed decision by:

Client Informed Refusal given to client: ❑ Yes ❑ No on Date ____/____/____ Date Required

Client Informed Refusal given to client by:
- ❑ Personal Contact / In the Office
- ❑ Phone Contact
- ❑ Postal Contact

❑ Client returned Client Informed Refusal incomplete

❑ Client failed to return a signed Client Informed Refusal

Attempts were made to give information to the client regarding:
- ❑ Diagnostic Services
- ❑ Diagnosis
- ❑ Treatment Services
- ❑ Treatment

Provider is unsure if the client has or is able to make an informed decision due to one or more of the following reason(s):
- ❑ No verbal communication with client
- ❑ Low literacy level
- ❑ Language / Translation issues
- ❑ Mental / Emotional disability
- ❑ Visual / Hearing impairment

_____ Date ____/____/____
Facility/Clinic/Agency Information - clinician name, clinic name, city name ***(do not abbreviate)***

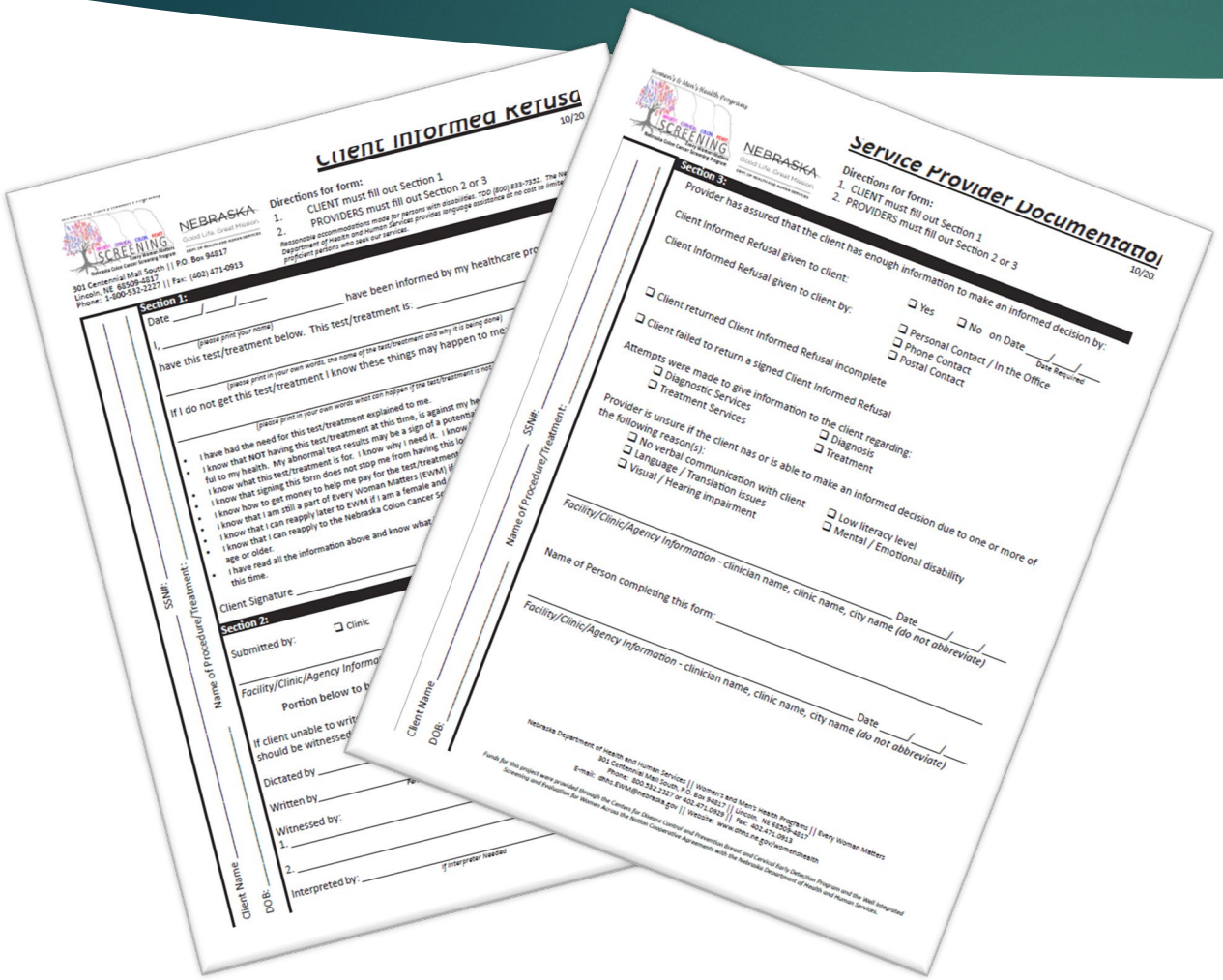
Name of Person completing this form: _____

_____ Date ____/____/____
Facility/Clinic/Agency Information - clinician name, clinic name, city name ***(do not abbreviate)***

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
Phone: 800.532.2227 or 402.471.0929 || Fax: 402.471.0913
E-mail: dhhs.EWM@nebraska.gov || Website: www.dhhs.ne.gov/womenshealth

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program and the Well Integrated Screening and Evaluation for Women Across the Nation Cooperative Agreements with the Nebraska Department of Health and Human Services.

Client Informed Refusal & Service Provider Documentation Forms



- Client Informed Refusal
  - Client must fill out SECTION 1.
  - Providers must fill out SECTION 2.
  - Providers need to fill in the following: Client name, DOB, SSN# and the name of the diagnostic procedure or treatment the client is refusing.
- Service Provider Documentation
  - Providers must fill out SECTION 3 if client fails to return the Client Informed Refusal form.

Spanish forms available online

Women Deemed Lost to Follow Up

Women's & Men's Health Programs

BREAST. CERVICAL. COLON. HEART.

Every Woman Matters

Nebraska Colon Cancer Screening Program

Report of Client Deemed Lost to Follow Up

Report of Client Deemed Lost to Follow Up

- All healthcare providers must make at least three (3) documented attempts at follow up for clients with abnormal results.
- The documentation must include the dates and types of contacts, as well as the results of the contact.
- Once a healthcare provider has exhausted all conventional means to contact a client to return for follow up, the client can be deemed lost to follow up.
- Provider should follow instructions located in the box: "*The client is considered lost to follow up only when:*"

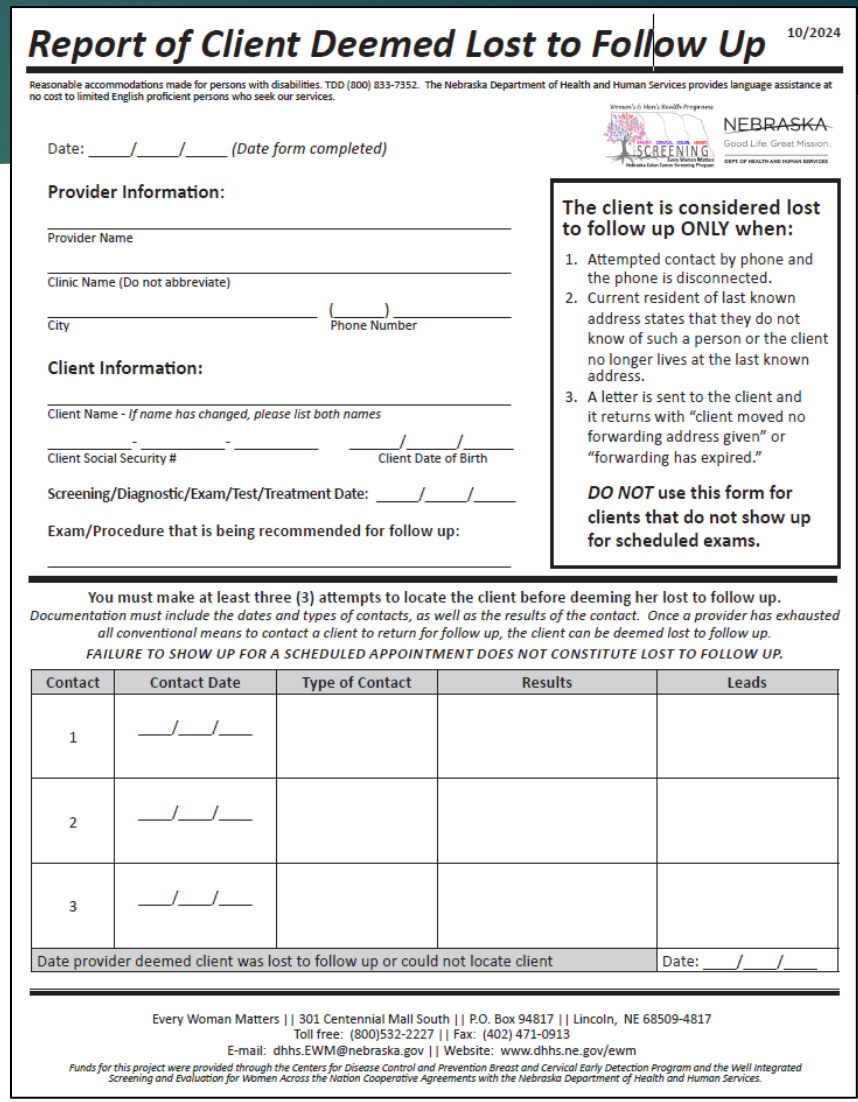
The client is considered lost to follow up ONLY when:

1. Attempted contact by phone and the phone is disconnected.
2. Current resident of last known address states that they do not know of such a person or the client no longer lives at the last known address.
3. A letter is sent to the client and it returns with "client moved no forwarding address given" or "forwarding has expired."

DO NOT **use this form for clients that do not show up for scheduled exams.**

Report of Client Deemed Lost to Follow Up

- **Failure to show up for a scheduled appointment does not constitute lost to follow up.**
- The healthcare provider submits the Report of Women Deemed Lost to Follow Up to EWM. The Program will attempt to locate the client to encourage her to return for follow up care.
- Please see the Lost to Follow Up Policy on page 70 within the Policy Section of the EWM/NCP Program Provider Manual.



Report of Client Deemed Lost to Follow Up 10/2024

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.

Date: ____/____/____ *(Date form completed)*

Provider Information:

Provider Name

Clinic Name (Do not abbreviate)

City Phone Number

Client Information:

Client Name - *If name has changed, please list both names*

Client Social Security # Client Date of Birth

Screening/Diagnostic/Exam/Test/Treatment Date: ____/____/____

Exam/Procedure that is being recommended for follow up:

The client is considered lost to follow up ONLY when:

1. Attempted contact by phone and the phone is disconnected.
2. Current resident of last known address states that they do not know of such a person or the client no longer lives at the last known address.
3. A letter is sent to the client and it returns with "client moved no forwarding address given" or "forwarding has expired."

***DO NOT* use this form for clients that do not show up for scheduled exams.**

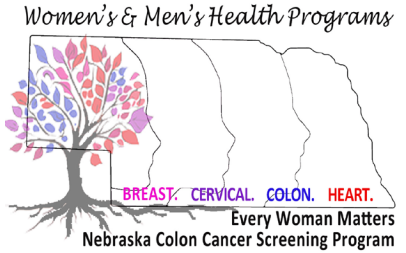
You must make at least three (3) attempts to locate the client before deeming her lost to follow up.
Documentation must include the dates and types of contacts, as well as the results of the contact. Once a provider has exhausted all conventional means to contact a client to return for follow up, the client can be deemed lost to follow up.
FAILURE TO SHOW UP FOR A SCHEDULED APPOINTMENT DOES NOT CONSTITUTE LOST TO FOLLOW UP.

Contact	Contact Date	Type of Contact	Results	Leads
1	___/___/___			
2	___/___/___			
3	___/___/___			
Date provider deemed client was lost to follow up or could not locate client				Date: ___/___/___

Every Woman Matters || 301 Centennial Mall South || P.O. Box 94817 || Lincoln, NE 68509-4817
Toll free: (800)532-2227 || Fax: (402) 471-0913
E-mail: dhhs.EWM@nebraska.gov || Website: www.dhhs.ne.gov/ewm

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program and the Well Integrated Screening and Evaluation for Women Across the Nation Cooperative Agreements with the Nebraska Department of Health and Human Services.

Claim Status Form

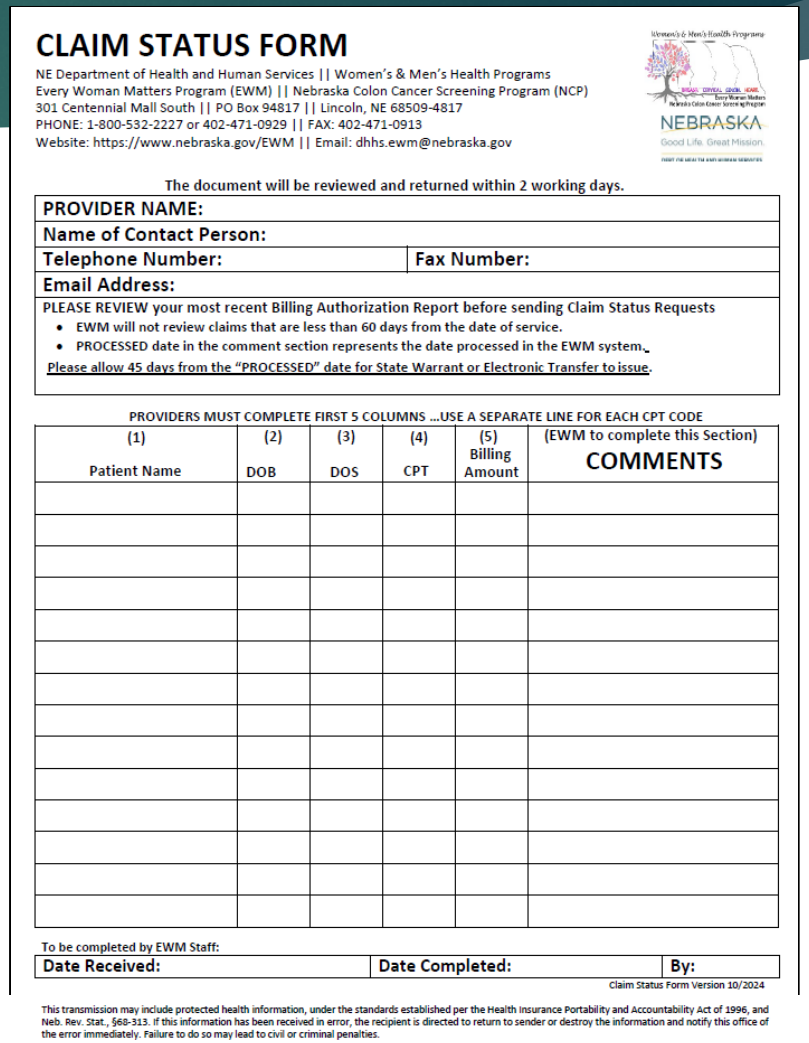


Claim Status Form

Claim Status Form

- This form is submitted when the Provider wants to know the status of a claim that has been submitted.

- Please see the Billing & Compensation Section on pages 54-58 within the EWM/NCP Program Provider Manual for additional information.
- The WMHP Fee for Service Schedule can be accessed online
- If Compensation & Billing Training is needed for your facility, please contact EWM at 1-800-532-2227



CLAIM STATUS FORM

NE Department of Health and Human Services || Women's & Men's Health Programs
Every Woman Matters Program (EWM) || Nebraska Colon Cancer Screening Program (NCP)
301 Centennial Mall South || PO Box 94817 || Lincoln, NE 68509-4817
PHONE: 1-800-532-2227 or 402-471-0929 || FAX: 402-471-0913
Website: https://www.nebraska.gov/EWM || Email: dhhs.ewm@nebraska.gov

NEBRASKA
Good Life. Great Mission.

The document will be reviewed and returned within 2 working days.

PROVIDER NAME:	
Name of Contact Person:	
Telephone Number:	**Fax Number:**
Email Address:	

PLEASE REVIEW your most recent Billing Authorization Report before sending Claim Status Requests

- EWM will not review claims that are less than 60 days from the date of service.
- PROCESSED date in the comment section represents the date processed in the EWM system.

Please allow 45 days from the "PROCESSED" date for State Warrant or Electronic Transfer to issue.

PROVIDERS MUST COMPLETE FIRST 5 COLUMNS ...USE A SEPARATE LINE FOR EACH CPT CODE

(1) Patient Name	(2) DOB	(3) DOS	(4) CPT	(5) Billing Amount	(EWM to complete this Section) COMMENTS

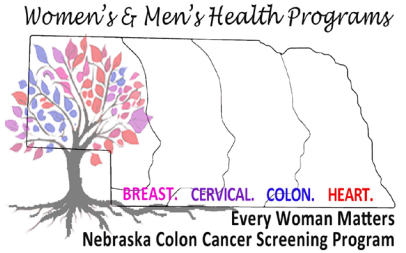
To be completed by EWM Staff:

Date Received:	**Date Completed:**	**By:**

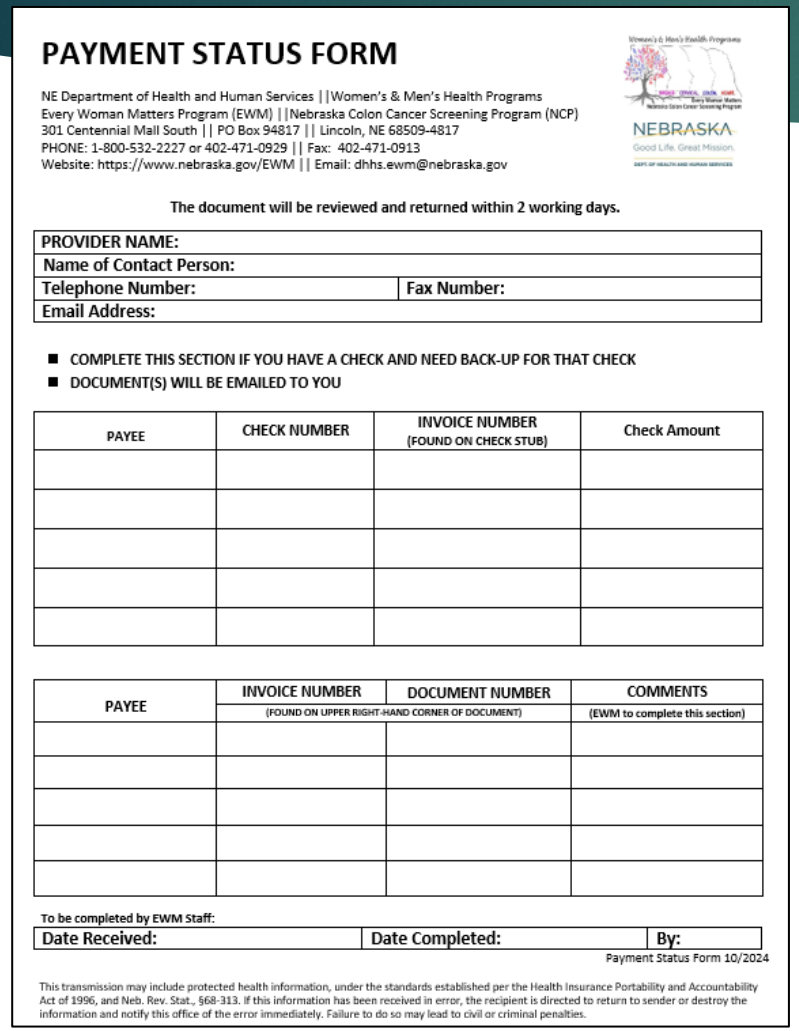
Claim Status Form Version 10/2024

This transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., §68-313. If this information has been received in error, the recipient is directed to return to sender or destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

Payment Status Form



Payment Status Form



PAYMENT STATUS FORM

NE Department of Health and Human Services ||Women's & Men's Health Programs
Every Woman Matters Program (EWM) ||Nebraska Colon Cancer Screening Program (NCP)
301 Centennial Mall South || PO Box 94817 || Lincoln, NE 68509-4817
PHONE: 1-800-532-2227 or 402-471-0929 || Fax: 402-471-0913
Website: https://www.nebraska.gov/EWM || Email: dhhs.ewm@nebraska.gov

NEBRASKA
Good Life. Great Mission.

The document will be reviewed and returned within 2 working days.

PROVIDER NAME:	
Name of Contact Person:	
Telephone Number:	Fax Number:
Email Address:	

- COMPLETE THIS SECTION IF YOU HAVE A CHECK AND NEED BACK-UP FOR THAT CHECK
- DOCUMENT(S) WILL BE EMAILED TO YOU

PAYEE	CHECK NUMBER	INVOICE NUMBER (FOUND ON CHECK STUB)	Check Amount

PAYEE	INVOICE NUMBER (FOUND ON UPPER RIGHT-HAND CORNER OF DOCUMENT)	DOCUMENT NUMBER	COMMENTS (EWM to complete this section)

To be completed by EWM Staff:

Date Received:	Date Completed:	By:

Payment Status Form 10/2024

This transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., §68-313. If this information has been received in error, the recipient is directed to return to sender or destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

Payment Status Form

- This form is submitted when the Provider receives a check and needs back-up for that check payment
- Please see the Billing & Compensation Section on pages 54-58 within the EWM/NCP Program Provider Manual for additional information.
- The WMHP Fee for Service Schedule can be accessed online
- If Compensation & Billing Training is needed for your facility, please contact EWM at 1-800-532-2227

Breast Cancer Resources

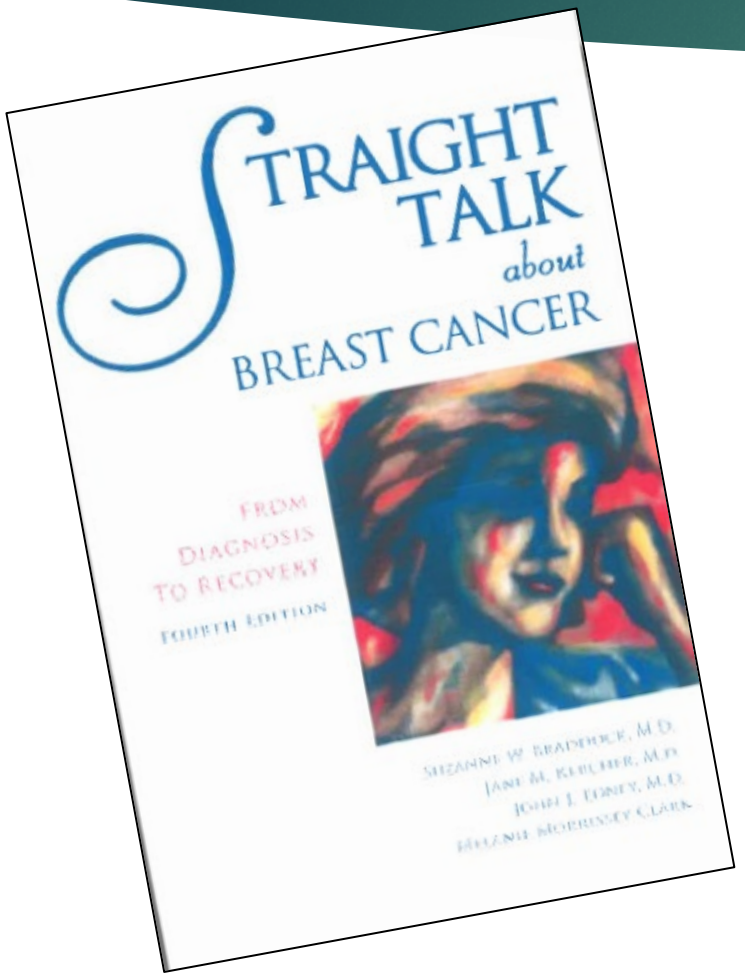
Women's & Men's Health Programs

BREAST. CERVICAL. COLON. HEART.

Every Woman Matters

Nebraska Colon Cancer Screening Program

Straight Talk About Breast Cancer



- Can request this resource for any woman in the state of Nebraska that has been diagnosed with breast cancer
- Available in English only

If You Have Breast Cancer

- American Cancer Society resource given to women in Nebraska that have been diagnosed with breast cancer.
- Available in English and Spanish

Additional Questions regarding the Other Forms?

Contact an Every Woman Matters representative:

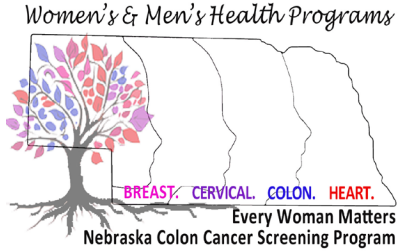
Women's & Men's Health Programs

1-800-532-2227 toll free

402-471-0913 fax

www.dhhs.ne.gov/womenshealth web

dhhs.ewm@nebraska.gov email



NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES