

**ForwardHealth
 Roster Billing Form
 Reimbursement for Treatment and Vaccination of the Uninsured**

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| SECTION I — PROVIDER INFORMATION | | |
| 1. Name--Participating Provider | 2. Name and Address--Service Delivery Site <i>Name:</i> <i>Address-Line 1:</i> <i>Address-Line 2:</i> <i>City, State, and ZIP:</i> | |
| 3. Telephone Number--Service Delivery Site | 4. National Provider Identifier--Service Delivery Site (if available) | 5. Invoice Number |

SECTION II — Roster of Rendered Services

Fill in the following information for each uninsured patient who received treatment or vaccination. If completing this form electronically, insert additional rows to accommodate additional patients.

| 6. First Name -- Patient | 7. Last Name -- Patient | 8. Middle Initial | 9. Rate Type | 10. Date of Birth | 11. Address --Patient (if available) | 12. Social Security Number (if available) | 13. Date of Service | 14. Antiviral Information | |
|--------------------------|-------------------------|-------------------|--------------|-------------------|--------------------------------------|---|---------------------|---------------------------|-------|
| | | | | | | | | Dosage | Lot # |
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Section III--Attestation of Uninsurance

The Participating Provider attests that, to the best of his or her knowledge, each patient listed on this form did not have any health insurance or was enrolled only in Wisconsin's Family Planning Waiver Program, the Wisconsin Chronic Disease Program, the Wisconsin Well Women Program, and/or Wisconsin's Tuberculosis-Related Services-Only (TB-Only) Program on the date of service indicated on this form for the patient.

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| 15. SIGNATURE — Authorized Agent of the Participating Provider (For paper submission, sign in this box. For electronic submission, enter the Participating Provider's name in this box.) | 16. Date Signed |
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