PROBATE CLAIMS NOTICE

Completion of this form is required according to Wis. Stat. §§ 859.07 (2), 867.01 (3)(d), and 867.02 (2)(d). Personally identifiable information will only be used in the administration of the Estate Recovery Section and will not be disclosed to other agencies. Consequences of failure to complete this form are covered under Wis. Stat. §§ 859.02 and 865.17.

In the matter of the estate of:	STATE OF WISCONSIN, Circuit Court Branch
Name – Deceased Member	County of Probate
Social Security Number (SSN)	Type of Probate
Date of Death	File Number
Date of Birth	Final Date to File Claims

☐ Check here if the **deceased member** has received one or more of the following:

- Medicaid or BadgerCare Plus benefits under Wis. Stat. ch. 49
- Medicaid or non-Medicaid benefits under a long-term care program as defined in Wis. Stat. § 49.496 (bk)s
- Medicaid Purchase Plan benefits under Wis. Stat. § 49.472
- Wisconsin Community Options Program benefits under Wis. Stat. § 46.27
- Wisconsin Chronic Disease Program benefits under Wis. Stat. §§ 49.68 through 49.685

☐ Check here if the **predeceased spouse** of the deceased member has received one or more of the following, and provide the requested information below (if more than one spouse, attach an additional sheet):

- Medicaid or BadgerCare Plus benefits under Wis. Stat. ch. 49
- Medicaid or non-Medicaid benefits under a long-term care program as defined in Wis. Stat. § 49.496 (bk)
- MAPP benefits under Wis. Stat. § 49.472
- COP benefits under Wis. Stat. § 46.27
- WCDP benefits under Wis. Stat.§§ 49.68 through 49.685

Name – Predeceased Spouse	SSN – Predeceased Spouse
Date of Birth – Predeceased Spouse	Date of Death – Predeceased Spouse

Disclosure of the SSN of a Medicaid member is mandatory, per 42 U.S.C. 1320b-7. Disclosure of the SSN of a non-Medicaid member is voluntary. The SSN will only be used for the identification of Medicaid, BadgerCare Plus, COP, and WCDP members and for the administration of the Estate Recovery Section.

Name – Personal Representative/Petitioner			Name – Attorney		
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code

MAILING: This form must be sent to the Department of Health Services Estate Recovery Section by certified mail at least 30 days prior to the date set under Wis. Stat. § 859.01, or as soon as possible after filing summary petitions under Wis. Stat. § 867.01 or 867.02.

Mail a copy to:

Wisconsin Department of Health Services
Division of Medicaid Services
Estate Recovery Section
PO Box 309
Madison WI 53701-0309

RESET FORM