Department of Workforce Development
Unemployment Insurance Division
P.O. Box 7905
Madison, WI 53707

Fax: (608) 260-2506
Email: UIDrugTest@dwd.wi.gov

Substance Abuse Treatment Provider Referral

Please return completed form by mail, fax or encrypted email within 7 days of the date of the assessment. Failure to return the form could result in the denial of benefits to the claimant and no payment for services will be processed.

Individual Information

First Name	Middle Initial	Last Name		
Address	City		State	Zip Code
Social Security Number	ID Number			

Treatment Facility Information

Treatment Facility Name			
Address	City	State	Zip Code
Contact Name	Title	Phone Number	

Treatment Facility Certification

☐ I (Name/Title) _____
certify that the individual requires substance abuse treatment that this facility is unable to provide.

Referral (Required):

Referral Substance Abuse Treatment Facility Name	Address	
City	State	Zip Code
Phone Number	Type of Treatment needed (Specific type/duration)	

Name of Treatment Facility Employee Completing This Form	Title
Phone Number	Date / /