WISCONSIN MEDICAID
SPECIAL PAYMENT RATE REQUEST FOR VENTILATOR-DEPENDENT
OR BRAIN INJURY CASES

Wisconsin Medicaid requires certain information to enable the programs to certify providers and to authorize and pay for medical services provided to eligible members.

Personally identifiable information about Medicaid providers is used for purposes directly related to program administration such as determining the certification of providers or processing provider claims for reimbursement. Non-submission of changes in address or status may result in incorrect reimbursement, misdirected payment, claim denial, or suspension of payments.

Provision of the information requested on this form is mandatory. This information received in any other format will be returned to the provider.

Completion and retention of this form is required under s. 7000 of the Hospital Inpatient State Plan. Failure to complete and submit this form may result in denial of Medicaid payment for the services.

INSTRUCTIONS

Type or print clearly. Mail completed forms to ForwardHealth, Provider Maintenance, 313 Blettner Boulevard, Madison, WI 53784.

Indicate the type of service being provided by the facility.

Type of Service (Check all that apply.)

❑ Ventilator — Long-Term Services
❑ Brain Injury — Neuro-Behavioral
❑ Brian Injury — Coma-Stem

Name — Provider (Required)

Provider ID (Required)	Practice Location ZIP+4 Code (Required)
Name — Contact Person	Telephone Number — Contact Person

Check the pertinent options below.

❑ This facility either has an inpatient unit or the entire facility is devoted solely to the care of members who are ventilator-dependent and the facility plans to request the special payment rate for services provided to ventilator-dependent members in the future.

❑ This facility plans to request the special payment rate for services provided to members with brain injury in the future.

SIGNATURE — Authorized Hospital Staff Member (Required)	Date Signed (Required)

F-01168