|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01210A (02/2017) | | | **STATE OF WISCONSIN** | |
| **IRIS BUDGET AMENDMENT PROVIDER QUOTE COMPARISON** | | | | |
| **INSTRUCTIONS:** | Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS Program requirement.  See page 2 of this form for detailed instructions. | | | |
|  | | **QUOTE NUMBER 1** | **QUOTE NUMBER 2** | **QUOTE NUMBER 3** |
| **Provider** | |  |  |  |
| **Service Being Requested** | |  |  |  |
| **Number of Units** | |  |  |  |
| **Rate** | |  |  |  |
| **Total Cost** | |  |  |  |
| **Participant Preference** | |  |  |  |
| **Reason for Participant’s Preference** | |  |  |  |
| **For DHS Use Only (Shaded Area)** | | | | |
| **Provider Approved by DHS** | |  |  |  |
| **Cost Approved by DHS** | |  |  |  |
|  | | | | |
| Name of ICA Staff | | | Email | |
| By completing and submitting this form, you are confirming that you have completed all required fields. You further confirm that all information provided has been reviewed, verified and is accurate to the best of your knowledge.  Please attach this form and any other relevant accompanying documents to the following link, in the appropriate file:  [**https://share.health.wisconsin.gov/ltc/teams/iris/iba/SitePages/Home.aspx**](https://share.health.wisconsin.gov/ltc/teams/iris/iba/SitePages/Home.aspx) | | | | |

|  |  |
| --- | --- |
| **INSTRUCTIONS FOR COMPLETING THE IRIS BUDGET AMENDMENT PROVIDER QUOTE COMPARISON FORM** | |
| **Who Should Use This Form**  This form should be used by IRIS Consultant Agencies serving participants who request a budget amendment. All relevant attachments should be submitted with this form | |
| **How to Complete This Form**  This form is to be completed and submitted electronically. This document is a fillable Microsoft Word document. TAB or CLICK between fields. | |
| \*\*ALL FIELDS ON THIS FORM ARE REQUIRED. AN INCOMPLETE FORM WILL RESULT IN PROCESSING DELAYS\*\* | |
| **Provider** | Insert name of provider |
| **Service Being Requested** | Insert service being requested – must be a service identified in the approved waiver |
| **Number of Units** | Identify the number of units |
| **Rate** | Identify rate charged by provider. Include unit – per mile, trip, hour, day, month, etc. |
| **Total Cost** | Insert bottom line total cost: number of units x rate |
| **Participant’s Preference** | Check the box of the provider the participant prefers |
| **Reason for Participant’s Preference** | Insert reason for participant choosing the provider they selected |
| **Provider Approved by DHS** | DHS will indicate their decision by checking the box of the provider they approve |
| **Cost Approved by DHS** | DHS will enter the cost approved |
| **Person Completing This Form**  Important things to remember:   * This form is to be completed for all budget amendment requests. * The purpose is to ensure that all quotes are comparable. * If it is discovered that the quotes are not comparable, the ICA must ensure that the quotes are updated to ensure that they are comparable before submitting the request to DHS. * The participant’s preference may not always be honored especially if another provider is more cost-effective. * The provider must be qualified and approved by Medicaid to provide the goods or services requested. | |
| The ICA staff that completes this form must also provide DHS with all relevant forms. When submitting this form, you are assuring that the information you provided has been verified and is accurate to the best of your knowledge. | |
| **How to Submit This Form**  This form and any relevant accompanying forms should be attached electronically to the DHS Budget Amendment SharePoint site, in the appropriate participant’s file. | |

.