

WISCONSIN MEDICAID / BADGERCARE PLUS REMAINING DEDUCTIBLE UPDATE

SECTION I – AGENCY INFORMATION

1. Agency Name	Agency Telephone Number	2. Agency Number	3. Worker ID
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SECTION II – MEMBER INFORMATION

4. Member's Name (Last, First, MI)		5. ForwardHealth ID Number	
6. Address – Street	City	State	Zip Code

SECTION III – GENERAL INFORMATION

7. Date of Service (mm/dd/yy)	8. Provider NPI	9. Member's Share
10. Amendment for Previous Form <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Previous Form Date (mm/dd/yy)	

12. Comments (attach a separate sheet if necessary)

SECTION IV – SIGNATURE

13. SIGNATURE – Agency Designee	Date Signed
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WI Stats. § .49.47(4) (c)

Distribution:

Medicaid Fiscal Agent

Provider

Agency Case File

MEDICAID BADGERCARE PLUS REMAINING DEDUCTIBLE UPDATE INSTRUCTIONS

This form is to be completed by the Consortia worker on the same day that the worker has completed processing the deductible in CARES. A large gap of time between the time the certification is completed and the time this form is keyed could mean the entire amount of the bill would be paid if the provider submitted the bill. When the deductible is met, notification of eligibility must be sent to the Medicaid Fiscal Agent, 313 Blettner Blvd. Madison, WI 53784-0001 or by fax to (608) 221-8815.

This form should only be used, if:

- a) The last bill, used to meet the deductible, can be considered for partial Medicaid/BadgerCare Plus payment of that bill, and
- b) The person who is being certified for Medicaid/BadgerCare Plus incurred the bill.

SECTION I – AGENCY INFORMATION

1. **Agency Name and Telephone Number** - Enter the name and telephone number of your agency.
2. **Agency Number** - Enter your agency's three-digit code number.
3. **Worker ID** - Enter your six-digit worker ID number.

SECTION II – MEMBER INFORMATION

4. **Member Name** - Enter the member's name (last, first, middle initial).
5. **ForwardHealth ID Number** - Enter the current ForwardHealth ID for the member whose bill is being used to determine if s/he has met the deductible.
6. **Address** - Enter the member's street address, city, state, and zip code.

SECTION III – GENERAL INFORMATION

7. **Date of Service** - Enter the dates of service for which is also the date the deductible was met. This is the same as the dates of service on the bill used to meet the deductible.
8. **Provider NPI Number** - Enter the provider NPI number of the provider whose bill is being used by the member to determine if s/he has met the deductible.
9. **Member's Share** - Enter the amount the member is responsible to pay on this bill.
10. **Amendment for Previous Form** - Check "Yes" if this is an amendment to a previous form. Check "No" if this is not an amendment to a previous form.
11. **Previous Form Date** - If you checked "Yes" an amendment to a previous form, enter the date of the previous form submitted.
12. **Comments** - Enter any comments.

SECTION IV - SIGNATURE

13. **Signature** - The agency designee must sign this form. Medicaid/BadgerCare Plus will not process forms without a signature.

Indicate your usual and customary charge for the service rendered on the appropriate claim form. The claim should be submitted through the regular channels for claiming reimbursement from the Medicaid/BadgerCare Plus program. The amount listed in field 9 will be deducted automatically from the Medicaid/BadgerCare Plus allowed amount for the service rendered. The balance will be considered for payment. (Reference [ForwardHealth Online Handbook](#).)

DISTRIBUTION: Medicaid Fiscal Agent

Provider whose bill met the deductible

Member's case file

Must be retained for three years.