wisconsin Medicaid update
and BadgerCare

September 2002 ● No. 2002-52
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Wisconsin Medicaid and BadgerCare Information for Providers

Two All-Provider Handbook forms revised

To:
All Providers
HMOs and Other Managed Care Programs

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

Effective immediately, the Provider Change of Address or Status (HCF 1181) and the Declaration of Supervision for Nonbilling Providers (HCF 1182) forms and their instructions have been revised. The forms in this *Wisconsin Medicaid and BadgerCare Update* replace the current forms in the All-Provider Handbook. Wisconsin Medicaid encourages providers to use the new forms in place of older versions.

Revised provider forms

Effective immediately, the Provider Change of Address or Status (HCF 1181) and the Declaration of Supervision for Nonbilling Providers (HCF 1182) forms and their instructions have been revised. Refer to Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update* for the revised forms and instructions.

Wisconsin Medicaid encourages providers to begin using the new, simpler forms in place of older versions of the forms. Providers have an ongoing responsibility to keep information current in their provider files. The revised forms replace the forms in the Provider Certification section of the All-Provider Handbook. Providers may mail the forms. Refer to the forms in this *Update* for the mailing address.

Wisconsin Medicaid Provider Change of Address or Status form

The Wisconsin Medicaid Provider Change of Address or Status form is recommended for Medicaid-certified providers who change their name, address, or tax information. The Second Opinion Registry information has been removed from the Provider Change of Address or Status form and the form's instructions have been expanded. Refer to the Provider Certification section of the All-Provider Handbook for examples of when providers must notify Wisconsin Medicaid of changes. Certified providers should not send Wisconsin Medicaid provider certification packet materials for name, address, or tax information changes.

Wisconsin Medicaid Declaration of Supervision for Nonbilling Providers form

Wisconsin Medicaid no longer requires the Wisconsin Medicaid Declaration of Supervision for Nonbilling Providers form for alcohol and other drug abuse (AODA) counselors, Master's-level psychotherapists, and psychiatric nurses. Consequently, the section of the form concerning these nonbilling mental health providers has been eliminated. The Division of Supportive Living (DSL), which certifies AODA counselors, Master's-level psychotherapists, and psychiatric nurses, already requires this information for DSL certification purposes. Therefore, Wisconsin Medicaid will utilize information collected by the DSL.

Medicaid-certified occupational therapy assistants, physician assistants, physical

therapist assistants, and speech therapists (bachelor of arts level) are still required to submit the Wisconsin Medicaid Declaration of Supervision form to Wisconsin Medicaid for name, address, supervisor, etc., changes. The form's instructions have also been expanded.

Obtaining copies of the revised forms

The following options are available to providers for obtaining the revised forms:

- Photocopy the forms included in Attachments 1 and 2.
- Refer to the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* to print a Portable Document Format (PDF) copy or to obtain a copy that providers may complete electronically. (See the "Electronic version of revised forms" section of this *Update* for more information on obtaining fillable PDF forms.)
- Create templates on their computers that include the same information as the forms included with this *Update*.
- Order copies of the forms by writing to Wisconsin Medicaid. Please include a return address, the number of copies needed, and the form name or form number. Mail the request to the following address:

  Wisconsin Medicaid
  Forms Reorder
  6406 Bridge Rd
  Madison WI 53784-0003

Electronic version of revised forms

Providers may obtain a fillable PDF version of the Wisconsin Medicaid Provider Change of Address or Status form and the Wisconsin Medicaid Declaration of Supervision for Nonbilling Providers form from the Medicaid Web site. The fillable PDF version allows providers to complete the form on their computer using Adobe Acrobat Reader®* and then print it. Providers are required to physically sign the forms and mail them to Wisconsin Medicaid. Electronic signatures are not accepted.

Obtain a free version of Adobe Acrobat Reader® at *www.adobe.com/*. To obtain fillable PDF versions of the forms, follow these steps:

- Go to the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.
- Click "Providers."
- Under "Provider Publications and Forms" select "Provider *Updates* By Date." (Providers may also choose "Provider *Updates* By Provider Type.")
- Under "Search for *Updates* by year" choose "2002" in the drop box and click "Go."
- Select *Update* number 2002-52.
- Select Attachment 1 or 2 within the text of the *Update* and save it to your computer.
- Click on the light gray boxes with the hand tool to enter information in each field. Press the "Tab" key to get to each field.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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* The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer. Refer to the Adobe® Web site, *www.adobe.com/*, for more information on fillable PDFs.

ATTACHMENT 1
Provider Change of Address or Status instructions and form

(A copy of the Provider Change of Address or Status instructions and the form are located on the following pages.)

WISCONSIN MEDICAID
PROVIDER CHANGE OF ADDRESS OR STATUS INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested may result in denial of Medicaid payment for those services.

INSTRUCTIONS

If a request is made to change an individual provider's file, Wisconsin Medicaid requires the individual provider's signature on the Wisconsin Medicaid Provider Change of Address or Status form. Signature stamps are not allowed.

Complete all areas of the form affected by change. A change in ownership, group affiliation, federal tax identification number (Internal Revenue Service [IRS] number), etc., must be reported to Wisconsin Medicaid *before* the change. A change in address must be reported immediately after moving.

SECTION I — PROVIDER INFORMATION

The information in this section pertains to the provider who performs Medicaid services and the location where the services are performed. Wisconsin Medicaid mails provider publications to this address.

Name — Provider

This is a required field. Enter the individual provider's first name, middle initial, and last name, or the name of the clinic or facility.

Name — Contact Person

If the contact person is different from the provider, enter his or her first name, middle initial, and last name here.

Wisconsin Medicaid Provider Number

This is a required field. Enter the provider's eight-digit Medicaid identification number. Do not enter any other numbers or letters. The provider number given must match the provider name listed in this section.

Medicare Provider Number

This is an optional field as some providers do not have a Medicare identification number. Enter the provider's Medicare identification number for the same services billed under the Wisconsin Medicaid number (i.e., hospital, physician clinic, and home health.) Providers without a Medicare identification number do not need to complete this field.

Attention

Enter the complete name of the person or department (i.e., billing) to whom provider publications should be directed.

Telephone Number — Provider

This is a required field. Enter the provider's telephone number, including the area code.

Street Address — Provider

Enter the provider's complete physical work address (street, city, state, and ZIP code). This address is the location where services are primarily provided. If the address is a rural route, indicate the fire number and directions to the provider's physical location in the space below the address field. A post office (P.O.) box number alone is *not* acceptable.

SECTION II — PAYEE AND TAX INFORMATION

Wisconsin Medicaid mails reimbursement checks and Remittance and Status (R/S) Reports to the address listed in this section.

Name — Payee

Enter the payee's first name, middle initial, and last name, or the name of the office, clinic, facility, or place of business. The payee name could be the same as the provider name listed in Section I but do not write "same" in this field.

Attention

Enter the complete name of the person or department (i.e., billing) where reimbursement checks and R/S Reports should be directed.

Address — Payee

Enter the payee's complete address (street, city, state, and ZIP code). The payee address could be the same as the one listed in Section I. A P.O. Box number alone *is* acceptable.

IRS Number — Payee

Enter the payee's IRS number. The IRS number listed must belong to the payee name provided in order to match IRS files. If the payee's name changes, the IRS number must be provided. (The IRS number may either be an Employee Identification Number, or for individuals, a Social Security number.)

IRS Number Effective Date

Enter the date (MM/DD/YYYY) that the IRS number became effective.

Signature — Provider

The provider's signature is *always required* on all requests to change the provider file. The provider's signature (first name, middle initial, and last name) must appear here. Signature stamps and electronic signatures are not acceptable.

Date Signed

This is a required field. Enter the month, day, and year (in MM/DD/YYYY format) this form was completed and signed.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1181 (Rev. 09/02)

STATE OF WISCONSIN
105.02(1), Wis. Admin. Code

WISCONSIN MEDICAID
PROVIDER CHANGE OF ADDRESS OR STATUS

SECTION I — PROVIDER INFORMATION

Name — Provider (required)	Name — Contact Person (if different than provider)
Wisconsin Medicaid Provider Number (required)	Medicare Provider Number
Attention	Telephone Number — Provider (required)

Street Address — Provider (P.O. Box alone not allowed)	City	State	Zip Code

If above is rural route, indicate fire number and directions to the provider's physical location:

_____

_____

_____ .

SECTION II — PAYEE AND TAX INFORMATION

Name — Payee	Attention
Address — Payee	City	State	Zip Code
IRS Number — Payee	IRS Number Effective Date

SIGNATURE — Provider (required)	Date Signed (required)

Mail to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

For more information, contact Provider Services at (800) 947-9627 or (608) 221-9883.

ATTACHMENT 2
Declaration of Supervision for Nonbilling Providers instructions and form

(A copy of the Declaration of Supervision for Nonbilling Providers instructions and the form are located on the following pages.)

WISCONSIN MEDICAID

DECLARATION OF SUPERVISION FOR NONBILLING PROVIDERS INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services.

INSTRUCTIONS

Nonbilling providers receive nonbilling provider numbers. The numbers *cannot be used independently* to bill Wisconsin Medicaid. The following nonbilling providers are required to complete the Declaration of Supervision for Nonbilling Providers form for changes in physical address and all supervisor changes:

- Occupational Therapy Assistant.
- Physical Therapist Assistant.
- Physician Assistant.
- Speech Therapist, bachelor of arts level.

The nonbilling provider(s) who has changed his or her work address or supervisor should complete Section I. The nonbilling provider's supervisor should complete Section II.

SECTION I — PROVIDER INFORMATION

Name — Nonbilling Provider and Credentials
Enter the nonbilling provider's first name, middle initial, and last name. Also include whether the nonbilling provider is an occupational therapy assistant, physical therapist assistant, physician assistant, or speech therapist, BA level.

Wisconsin Medicaid Provider Number
Enter the nonbilling provider's eight-digit Medicaid identification number. Do not enter any other numbers or letters.

Address — Nonbilling Provider
Enter the nonbilling provider's complete physical work address (street, city, state, and ZIP code). A post office (P.O.) box number alone is *not* acceptable.

Telephone Number — Nonbilling Provider
Enter the nonbilling provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Provider Reimbursement Statement
In the space labeled "Name — Provider," write the complete name of the nonbilling provider. In the space labeled "Name — Clinic or Supervisor" write the name of the clinic or supervisor where Wisconsin Medicaid will send reimbursement.

Signature — Nonbilling Provider
The signature of the nonbilling provider is required here. Signature stamps and electronic signatures are not acceptable.

Date Signed
Enter the month, day, and year (in MM/DD/YYYY format) this form was completed and signed. This is a required field.

SECTION II — SUPERVISOR INFORMATION

Name — Supervisor
Enter the supervisor's first name, middle initial, and last name.

Wisconsin Medicaid Provider Number
Enter the supervisor's eight-digit Medicaid identification number, if applicable. Do not enter any other numbers or letters.

IRS Number — Employer
Enter the nine-digit federal tax identification number (Internal Revenue Service [IRS] number) of the supervisor's employer.

Address — Supervisor
Enter the supervisor's complete physical work address (street, city, state, and ZIP code).

Telephone Number — Supervisor
Enter the supervisor's telephone number, including the area code, of the office, clinic, facility, or place of business.

Supervisor Reimbursement Statement
In the space labeled "Name — Supervisor," write the complete name of the nonbilling provider's supervisor. In the space labeled "Name — Provider," write the complete name of the nonbilling provider. In the space labeled "Supervisor's Effective Starting Date," enter the month, day, and year (in MM/DD/YYYY format) when this person began supervising the nonbilling provider's work.

Signature — Supervisor
The signature of the supervisor must appear here. Signature stamps and electronic signatures are not allowed.

Date Signed
Enter the month, day, and year (in MM/DD/YYYY format) this form was completed and signed.

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1182 (Rev. 09/02)

WISCONSIN MEDICAID
DECLARATION OF SUPERVISION FOR NONBILLING PROVIDERS

SECTION I — PROVIDER INFORMATION

Name and Credentials — Nonbilling Provider	Wisconsin Medicaid Provider Number
Address — Nonbilling Provider	Telephone Number — Nonbilling Provider

I,_____, direct Wisconsin Medicaid to make checks payable to
(Name — Provider)

_____ for all claims payments for services performed by me
(Name — Clinic or Supervisor)

under Wisconsin Medicaid since Wisconsin Medicaid cannot reimburse me.

I understand that this payment arrangement will continue in effect until Wisconsin Medicaid receives a new Declaration of Supervision form from me. When my supervisor, employer, or work address changes, I will immediately send this completed form to Wisconsin Medicaid.

SIGNATURE — Nonbilling Provider (required)	Date Signed (required)

SECTION II — SUPERVISOR INFORMATION

Name — Supervisor	Wisconsin Medicaid Provider Number	IRS Number — Employer
Address — Supervisor		Telephone Number — Supervisor

I,_____, am supervising the work of_____.
(Name — Supervisor) (Name — Provider)

The effective starting date of my supervision was _____. I hereby acknowledge and
(Supervisor's Effective Starting Date)
agree to the above payment arrangement.

I understand that if my name is indicated in Section I above, Wisconsin Medicaid payment for services provided by the above provider will be payable to me directly and will be reported under the IRS number written above. If I discontinue supervision of the above provider, I understand that I must notify Wisconsin Medicaid at the address at the bottom of this page.

SIGNATURE — Supervisor	Date Signed

Mail to:
Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

For more information, contact Provider Services at (800) 947-9627 or (608) 221-9883.