

## GOOD FAITH MEDICAID / BADGERCARE PLUS CERTIFICATION INSTRUCTIONS

The shaded areas of the Good Faith Certification form is to be completed by the Medical Fiscal Agent.

Sections 1 and 3 of this form are to be completed by the Income Maintenance worker. Return the completed original form to:

Medicaid Fiscal Agent  
P.O. Box 7636  
Madison, WI 53707  
Fax: (608) 221-8815

### SECTION I – AGENCY DENIAL

#### **Agency Denial**

If the member identified on this Good Faith Certification form was neither eligible nor possessed a valid temporary “*ForwardHealth*” ID card for the dates of service indicated in field six, check the “Yes” box. If you check “Yes” here, you must also check the reasons in the next field.

#### **Reason for Denial**

- Member did not have a valid “Forward” ID card after \_\_\_\_\_ (date).

Check this box if you are certain that the member did not possess a valid temporary “Forward” ID card for the date of service. In the blank provided, enter the closing date of eligibility.

- Member not eligible.

Check this box if the member was not eligible for the dates of service shown. If the member was eligible for some of the dates of service, follow the instructions for completing the Partial Denial box.

- Record not found.

Check this box if the client has never been eligible for Medicaid in your agency.

#### **Partial Deny**

Use this field if the member was eligible for some of the dates of service. Enter the “From” and “To” dates which cover the portion of the dates of service for which the member does not have eligibility on MMIS and should have.

### SECTION II – TYPE OF CERTIFICATION ACTION

This entire section is completed by the Medicaid Fiscal Agent with all known information.

#### **Initial Certification / Amended Certification**

Check the appropriate box.

#### **Agency Number**

Enter the three-digit code of the agency they believe may have certified the member during the dates in question.

#### **W-2 Agency Code**

Enter the W-2 agency code.

**Case Head ID Number**

Enter the known or suspected MMIS case head number of the member listed on the provider's claim.

**Medical Status Code**

When Medicaid receives the provider's claim along with a photocopy of a temporary "ForwardHealth" ID card the Medicaid compares the dates of service with the dates on the card. If the dates of service fall within the dates of eligibility on the card submitted by the provider, for the member's ID number, Medicaid enters a "71" medical status code and pays the claim immediately, if there is no eligibility on file. Medicaid then enters the eligibility dates for the entire month in which services were provided.

**Period of Certification**

If Medicaid has entered the suspected period of certification to be added to the member master file, check it for accuracy. Complete a Medicaid / BadgerCare Plus Certification form (F-10110) and enter the period of certification if the member file does not show eligibility for the time when the member was eligible or for the time covered by a temporary "Forward" ID card issued to the member.

**Case Head Name**

Medicaid enters the case head's last name, first name and middle initial, if known.

**In Care Of**

Medicaid enters the name of the person to whom information should be sent in care of, if not sent directly to the member.

**Address**

Medicaid enters the member's address, including street, city, state and zip code, if known.

**Control Name Year of Birth (YOB)**

Medicaid will enter the suspected control name and year of birth (YOB) for the member. The YOB is the last two digits of the member's year of birth.

**Eligibility Member Name**

Medicaid enters the eligible member's last name, first name and middle initial.

**Birthdate**

Medicaid completes this field only for initial certifications. Change this birthdate if the date entered is incorrect. Indicate birthdate as mm/dd/ccyy.

**Gender**

Medicaid completes.

**Other Remarks:**

Medicaid enters other necessary information.

**SECTION III – SIGNATURE**

**Signature**

Good Faith forms must have an authorized signature for initial certifications. The authorized agency Representative must sign here.

**Worker ID Number**

On initial certifications, enter the six-digit worker code of the certifying economic support worker.

**Date Signed**

Enter the date (mm/dd/ccyy) of the date the authorized agency representative signed the form.