Medicaid Billing Verification 2015

Waiver Support Coordinator_____

Month and Year_____

The following consumers will not be billed on for the month and year identified above due to my inability to complete the Medicaid billing requirements as identified in the *Developmental Disabilities Waiver Coverage and Limitations Handbook*:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

I verify that other than the consumer names identified above, the rest of the consumers I serve as identified on my case load list are billable. I verify that all Medicaid required documents as identified in the *Developmental Disabilities Waiver Coverage and Limitations Handbook* are completed, signed and filed in my chart and all case note documentation is up to date, completed, documented and filed in my chart prior to submitting for Medicaid reimbursement for the month and year identified above. I understand that no Medicaid billing will be submitted for the month and year identified above until I have signed and dated and submitted this form to Barbara Thomas, President of Emerald Coast Support Coordinators, Inc..

I understand that if I do not identify a consumer as not billable and Medicaid billing is completed on that consumer and it is later discovered that all of the requirements had not been met for the month billed, a void for that claim will be submitted to Medicaid and my payback to Emerald Coast Support Coordinators, Inc. will be the full Medicaid reimbursement for that consumer for that billable month. I further understand the seriousness of billing for consumers who do not meet Medicaid billable requirements as stated in the above identified handbook and if a trend is discovered by the officers of Emerald Coast Support Coordinators, Inc., I may be subject to punitive action.

WSC Signature_____

Date of Signature_____

Supervisor Signature_____