

## WISCONSIN MEDICAID RURAL HEALTH CLINIC QUARTERLY COST REPORT INSTRUCTIONS

Wisconsin Medicaid requires information to enable the programs to certify providers and to authorize and pay for medical services provided to eligible members. Although these form instructions refer to Wisconsin Medicaid, this form also applies to the BadgerCare Plus Standard Plan.

Personally identifiable information about providers is used for purposes directly related to program 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 the services.

The use of this form is voluntary, but providers must collect and maintain all information on the form in some format if they wish to submit a cost report.

### INSTRUCTIONS

The Rural Health Clinic Quarterly Cost Report form may be completed by provider-based and independent rural health clinics (RHCs) and submitted to Wisconsin Medicaid.

### QUARTERLY COST REPORT COMPLETION AND DEADLINES

RHCs are responsible for accurate completion and submission of the RHC Quarterly Cost Reports. To receive a quarterly reconciliation payment, submit a quarterly cost report to the following address:

Rural Health Clinic Auditor  
Bureau of Program Integrity  
Office of the Inspector General  
PO Box 309  
Madison WI 53701-0309

For all lines, report encounters with dates of service within the reporting period only.

### SECTION I – RHC INFORMATION

List the full name of the clinic, the clinic's address, and the RHC billing provider's National Provider Identifier (NPI) and Medicaid provider numbers.

### SECTION II – DETERMINATION OF SETTLEMENT

Enter the RHC fiscal year end and the quarterly reporting period dates.

### SECTION III – DETERMINATION OF REIMBURSEMENT

**Line 1:** Report the encounter rate used on the most recently audited cost report by Wisconsin Medicaid. (Note: Quarterly cost reports can only be submitted after a clinic has operated as an RHC continuously for 12 months.)

**Line 2:** Report Medicaid encounters submitted to Wisconsin Medicaid or Medicaid HMOs for which payments have been received.

**Lines 4a and 4b:** Report Medicaid fee-for-service and Medicaid HMO payments received separately.

**Line 4c:** Report Medicare payments received for Medicare/Medicaid encounters.

**Line 4d:** Report commercial insurance payments.

**Line 4e:** Report total copayments due to the provider from Medicaid members. This amount may be different from the amount actually received by the provider if all copayments have not been paid.

**Line 5:** Represents the quarterly payment due to the provider.

### SECTION IV – SIGNATURES

- Enter the name and phone number of the person preparing the report, and sign and date the form.
- Enter the name and phone number of the clinic manager or administrator, and sign and date the form.

The authorized individual who signs the annual Medicaid RHC cost reports must sign this cost report.