



TO: All Providers and Managed Care Organizations
RE: Presumptive Eligibility Certification and Guarantee of Payment Form, W-538

This bulletin is being sent to all enrolled Connecticut Medical Assistance Program providers to inform you of the W-538 form which has been revised and will be used to guarantee payment for medical services for children under the age of nineteen and pregnant women. The W-538 "Medicaid Presumptive Eligibility Certification and Guarantee of Payment", (copy on reverse side) is used for Qualified Entities (QE) to grant presumptive eligibility for children and Qualified Providers (QP) to grant presumptive eligibility for pregnant women. This form is good only for a period of five days from the date listed at the top of the form and is used when a child or pregnant woman has been determined to be presumptively eligible for Medicaid.

Please note: you may continue to accept the previous version of the W-538 (8/00) until the QE/QP receive their stock of the revised W-538 (3/10).

Before submitting a claim for processing, every effort should be made to identify if the child or pregnant woman has an eligible Medicaid client ID number through one of the options provided by the Automated Eligibility Verification Systems (AEVS). To process eligibility verification without a client ID, providers should use the Identifying Information (Date of Birth and Social Security Number) found on the W-538. **If the client has an eligible Medicaid client ID, the W-538 form should not be submitted and the claim should be submitted directly to HP or to the Managed Care Organization in which the client is enrolled.**

The INSTRUCTIONS TO THE PROVIDER Section has the incorrect Hartford area telephone number listed. The number should read 860-269-2028.

If the child or pregnant woman does not have an eligible Medicaid client ID number, leave the Medicaid Identification section of the claim form blank and submit a copy of the W-538 form with the Medicaid claim form to:

Department of Social Services
Bureau of Assistance Programs
Family Support Unit, 10th floor
25 Sigourney Street
Hartford, CT 06106-5033

Please note that only active Medicaid Providers will be reimbursed at the fee established by the Department of Social Services for the service provided.



MEDICAID PRESUMPTIVE ELIGIBILITY CERTIFICATION AND GUARANTEE OF PAYMENT

Date: _____

The individuals listed below have been determined to be presumptively eligible for Medicaid (HUSKY A). The Department of Social Services guarantees payment* for medical services provided for these individuals for a period of five days from the date shown above.

IDENTIFYING INFORMATION			
Individual's Name	Gender	Date of Birth	Social Security Number
	<input type="checkbox"/> Male		
	<input type="checkbox"/> Female	/ /	
	<input type="checkbox"/> Male	/ /	
	<input type="checkbox"/> Female	/ /	
	<input type="checkbox"/> Male	/ /	
	<input type="checkbox"/> Female	/ /	
	<input type="checkbox"/> Male	/ /	
	<input type="checkbox"/> Female	/ /	

VOID VOID

VOID VOID

Authorized By: _____
Qualified Entity/Qualified Provider Worker/Organization

Telephone Number: _____

INSTRUCTIONS TO THE PROVIDER

Make every effort to identify if the individual has an eligible Medicaid (HUSKY A) client ID number through the Automated Eligibility Verification System (AEVS) 1-800-842-8440 (860-409-4500 in the Hartford area).

DO NOT USE THIS FORM if the individual has an eligible Medicaid (HUSKY A) client ID number.

If the individual does not have an eligible Medicaid client ID number, leave the Medicaid Identification section of the claim form blank and submit a copy of this form with your Medicaid claim form to:

Department of Social Services
Family Services Division
Family Support Unit
25 Sigourney Street
Hartford, CT 06106-5033
Fax # 860-424-4970

***(Please note that only active Medicaid Providers will be reimbursed, at the fee established by the Department of Social Services for the service provided.)**

INSTRUCTIONS TO CARETAKER – INSTRUCCIONES PARA EL GUARDIAN

Use this form to secure medical services for the individual(s) listed above. Remember this form is only valid for five days from the date listed above. You should receive an eligibility approval notice and a Medicaid CONNECT card by the end of this period. If you do not receive the approval notice and CONNECT card or if you have any questions, please call 860-424-5540.

Use esta forma para asegurar servicios médicos para él/los individuo(s) listado(s) arriba. Recuerde esta forma es solamente válida por cinco días desde la fecha listada arriba. Usted deberá recibir un aviso de elegibilidad aprobada y una tarjeta CONNECT para el final de este periodo. Si usted no recibe el aviso de elegibilidad y la tarjeta CONNECT o si usted tiene preguntas, favor de llamar al 860-424-5540.

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.