ATTACHMENT 12

Texas Department of Human Services/Form 1027-A/1-2000

MEDICAID ELIGIBILITY VERIFICATION
CONFIRMACIÓN DE ELEGIBILIDAD PARA MEDICAID

	Name of Doctor/Nombre del Doctor	Name of Pharmacy/Nombre de la Farmacia

THIS FORM COVERS ONLY THE DATES SHOWN BELOW. IT IS NOT VALID FOR ANY DAYS BEFORE OR AFTER THESE DATES.
ESTA FORMA ES VÁLIDA SOLAMENTE EN LAS FECHAS INDICADAS ABAJO. NO ES VÁLIDA NI ANTES NI DESPUÉS DE ESTAS FECHAS.

❑ **Each person listed below has applied for and is eligible for MEDICAID BENEFITS for the dates indicated below, but has not yet received a client number. Do not submit a claim until you are given a client number. Pharmacists have 90 days from the date the number is issued to file clean claims. However, check your provider manual because other providers may have different filing deadlines. Call the eligibility worker named below if you have not been given the client number(s) within 15 days.**

❑ **Each person listed below is eligible for MEDICAID BENEFITS for dates indicated below. The Medicaid Identification form is lost or late. The client number must appear on all claims for health services.**

Date Eligibility Verified	Verification Method	BIN
	❑ Local DCU ❑ SAVERR Direct Inquiry ❑ Regional Procedure ❑ S.O. DCU (A & D Staff) Only)	610098

CLIENT NAME NOMBRE DEL CLIENTE	DATE OF BIRTH FECHA DE NACIMIENTO	CLIENT NO. CLIENTE NÚM.	ELIGIBILITY DATES PERIODO DE ELEGIBILIDAD		MEDICARE CLAIM NO. NÚM. DE RECLAMO DE MEDICARE	STAR/STAR+PLUS HEALTH PLAN INFORMATION INFORMACIÓN DEL PLAN DE SALUD STAR/STAR+PLUS Plan Name and Member Services Toll-Free Telephone No. Nombre del Plan y el Teléfono de Servicios para Miembros para Llamar Gratis
			From/Desde	Through/Hasta		

I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid Identification (Form 3087) for the current month. I have requested and received Form 1027-A, Medicaid Eligibility Verification, to use as proof of eligibility for the dates shown above. I understand that using this form to obtain Medicaid benefits (services or supplies) for people not listed above is fraud and is punishable by fine and/or imprisonment.

Por este medio certifico, bajo pena perjurio y/o fraude, que los clientes nombrados arriba hemos perdido, no hemos recibido o por otra razón no tenemos en nuestro poder la Identificación para Medicaid (Forma 3087) del corriente mes. Solicité y recibí esta Confirmación de Elegibilidad Médica (Forma 1027-A) para comprobar nuestra elegibilidad para Medicaid durante el periodo cubierto especificado arriba. Comprendo que usar esta confirmación para obtener beneficios (servicios o artículos) de Medicaid para alguna persona no nombrada arriba como beneficiario constituye fraude es castigable por una multa y/o la cárcel.

CAUTION: If you accept Medicaid benefits (services or supplies), you give and assign to the state of Texas your right to receive payments for those services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

ADVERTENCIA: Si usted acepta beneficios de Medicaid (servicios o artículos), otorga y concede al estado de Texas el derecho a recibir pagos por los servicios o artículos de otras compañías de seguros y otras fuentes responsables, hasta completar la cantidad que se requiere para cubrir lo que haya gastado Medicaid.

Signature–Client or Representative/Firma–Cliente o Representante Date/Fecha

Office Address and Telephone No./Oficina y Teléfono

Name of Worker (type)/Nombre del Trabajador	Worker BJN	WORKER SIGNATURE	Date
		X	▶
Name of Supervisor* (type)/Nombre del Supervisor*	**Supervisor* BJN**	**SUPERVISOR SIGNATURE**	**Date**
		X	▶

*or Authorized Lead Worker/ *o Trabajador Encargado