wisconsin Medicaid update
and BadgerCare

October 2002 ● No. 2002-57
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Wisconsin Medicaid and BadgerCare Information for Providers

To:
All Providers
HMOs and Other Managed Care Programs

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

Revised form for indicating discrepancies in recipients' other health care coverage information

Wisconsin Medicaid has revised the Other Coverage Discrepancy Report form. Providers are encouraged to discontinue using old versions of the form and begin using the new form, HCF 1159, dated 10/02.

Form revised for easier use

Wisconsin Medicaid has revised the Other Coverage Discrepancy Report form in an attempt to make it clearer and easier to complete. Providers should use this form to notify Wisconsin Medicaid of information that contradicts Wisconsin Medicaid's records on a recipient's other health care coverage.

Wisconsin Medicaid encourages providers to discontinue using old versions of the form and begin using the new form, HCF 1159, dated 10/02. The new form, which may be photocopied for future use, is included as the Attachment of this *Wisconsin Medicaid and BadgerCare Update*.

The new form is also available in a fillable Portable Document Format (PDF) from the forms section of the Wisconsin Medicaid Web site. To get to this section, go to *www.dhfs.state.wi.us/medicaid/*. Choose "Providers" from the options listed in the Wisconsin Medicaid main menu. Then choose "Provider Forms" from the "Provider Publications and Forms" topic area.
The fillable PDF may be accessed using Adobe Acrobat Reader®* and completed electronically. To use the fillable PDF, click on the dash-outlined boxes to enter information. Press the "Tab" key to move from one box to the next.

To request paper copies of the new form, call Provider Services at (800) 947-9627 or (608) 221-9883. Questions about the Other Coverage Discrepancy Report form may also be directed to Provider Services at the telephone numbers above.

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*The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site at *www.adobe.com/*. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer. Refer to the Adobe® Web site for more information on fillable PDFs.

ATTACHMENT
Revised Other Coverage Discrepancy Report form

(A copy of the revised "Other Coverage Discrepancy Report" form is located on the next page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1159 (Rev. 02/04)

WISCONSIN MEDICAID
OTHER COVERAGE DISCREPANCY REPORT

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement.

The use of this form is voluntary; providers may develop their own form as long as it includes all the information on this form. Attach additional pages if more space is needed.

INSTRUCTIONS: Use this form to notify Wisconsin Medicaid of discrepancies between other health care coverage information obtained through the Eligibility Verification System and information received from another source. Always complete Sections I and IV. Complete Sections II and/or III as appropriate. Wisconsin Medicaid will verify the information provided and update the recipient's file (if applicable). Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly. Type or print clearly.

SECTION I ¾ PROVIDER AND RECIPIENT INFORMATION

Name — Provider (Last, First, Middle Initial)	Wisconsin Medicaid Provider Number

Name — Recipient (Last, First, Middle Initial)	Date of Birth — Recipient	Recipient Medicaid Identification Number

SECTION II ¾ MEDICARE PART A AND B COVERAGE

Medicare / HIC Number

☐ Add		☐ Remove	
☐ Part A Coverage	Start Date	☐ Part A Coverage	End Date
☐ Part B Coverage	Start Date	☐ Part B Coverage	End Date

SECTION III ¾ COMMERCIAL INSURANCE, MEDICARE SUPPLEMENTAL, AND MEDICARE MANAGED CARE COVERAGE

☐ Add	☐ HMO	☐ Medicare Managed Care
☐ Remove	☐ Medicare Supplement	☐ Other

Name — Insurance Company

Address — Insurance Company (Street, City, State, Zip Code)

Name — Policyholder (Last, First, Middle Initial)		Social Security Number — Policyholder
Policy Number	Coverage Start Date	Coverage End Date

Recipient Left HMO Service Area ☐ Yes ☐ No	Date Recipient Left HMO Service Area (If Applicable)

SECTION IV ¾ REPORT INFORMATION

Name — Individual Completing This Report	Date Signed	Telephone Number / Extension
Name — Source of Information Included on This Report		Telephone Number / Extension

Mail to	Fax to	Comments
Wisconsin Medicaid Coordination of Benefits 6406 Bridge Rd Madison WI 53784-6220	Coordination of Benefits (608) 221-4567	(Attach additional pages if necessary.)

Reset Form