wisconsin Medicaid update
and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
All Providers
HMOs and Other Managed Care Programs

Introducing the Wisconsin Medicaid Claim Refund form and instructions

Wisconsin Medicaid is introducing the Wisconsin Medicaid Claim Refund form for providers to use when making cash refunds to Wisconsin Medicaid. Wisconsin Medicaid will accept this voluntary form beginning October 1, 2003.

New Claim Refund form

Wisconsin Medicaid is introducing the Claim Refund form in conjunction with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Providers can choose to use this voluntary form when making cash refunds to Wisconsin Medicaid. Providers can also choose to return the paper Remittance and Status Report with their refund, using the instructions in the Claims Submission section of the All-Provider Handbook. For nursing home returned drugs, pharmacies may continue to use the instructions in the Claims Submission section of the Pharmacy Handbook.

When returning a Medicaid-issued check or making a refund with a provider-issued check, one refund form should be completed per payer control number or internal control number pertaining to the refund. The provider-issued refund check should be made payable to Wisconsin Medicaid. Mail the Claim Refund form and either the Medicaid-issued check or provider-issued refund check to the following address:

Wisconsin Medicaid
Financial Services Cash Unit
6406 Bridge Rd
Madison WI 53784-0004

Use of the Claim Refund form is voluntary. Providers may develop their own form as long as it includes all the information on the Claim Refund form. Attach additional pages if more space is needed.

Note: Providers should not use the Claim Refund form for provider-based billing claims. Follow the appropriate instructions for these claims.

Obtaining copies of the Claim Refund form

The Claim Refund, HCF 13066, dated 07/03, which may be photocopied, is included as Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update*. Refer to Attachment 1 for the completion instructions of this form.

The Claim Refund form will also be 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 PDFs may be accessed using Adobe Acrobat Reader®* and completed electronically. To use a fillable PDF, click on the dash-outlined boxes to enter information. Press the "Tab" key to move from one box to the next. Once completed, the PDF should be printed and mailed.

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

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care HIPAA-related changes, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

*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.

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/*.

ATTACHMENT 1
Claim Refund Completion Instructions

(The "Claim Refund Completion Instructions" are located on the following pages.)

WISCONSIN MEDICAID
CLAIM REFUND COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires the information indicated below to properly post a refund. Providers can submit either refunds or adjustment requests per payer control number (PCN) or internal control number (ICN), but should not do both. Adjustments must be submitted using the Adjustment/Reconsideration Request Form.

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, processing prior authorization (PA) requests, or processing provider claims for reimbursement.

Questions about refunds and other procedures or policies may be directed to Provider Services at (800) 947-9627 or (608) 221-9883. Mail this form to the address on the Claim Refund form.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. Attach additional pages if more space is needed. Providers may photocopy the Claim Refund form for their own use.

INSTRUCTIONS
Type or print clearly.
Enter the following information from the provider's 835 Health Care Claim Payment/Advice transaction or the Remittance and Status (R/S) Report.

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

Element 1 — Payee / Billing Provider's Medicaid Provider Number
Enter the payee or billing provider's eight-digit Medicaid provider number to which the claim was paid.

Element 2 — Name — Payee / Billing Provider
Enter the payee or billing provider's name that corresponds to the provider number in Element 1.

Element 3 — Subscriber / Recipient Medicaid Identification Number
Enter the subscriber's or recipient's 10-digit Medicaid identification number.

Element 4 — Name — Subscriber / Recipient
Enter the complete name of the subscriber or recipient for whom payment was received.

SECTION II — CLAIM INFORMATION

Element 5 — Payer Control Number / Internal Control Number (15 digits)
Enter the PCN from the 835 Health Care Claim Payment/Advice transaction or the ICN from the R/S Report of the paid or allowed claim. (Use the claim number assigned to the most recently processed claim or adjustment.)

Element 6 — Check Issue Date / Report Date
Enter the check issue date from the 835 Health Care Claim Payment/Advice transaction or the date of the R/S Report showing the paid claim the provider is refunding.

Element 7 — Date(s) of Service
Enter the month, day, and year for each procedure.

Element 8 — Procedure Code / National Drug Code / Revenue Code
Enter the procedure code for which the refund is being applied.

Element 9 — Modifiers 1-4
Enter the appropriate modifier(s).

Element 10 — Billed Amount
Enter the total billed amount for each line item.

Element 11 — Refund Amount
Enter the total refund amount for each line item.

Element 12 — Refund Total
Enter the total refund amount for the specific claim.

SECTION III — REFUND INFORMATION

Element 13 — Reason for Refund
Check the most appropriate box indicating the provider's reason for submitting the refund:

- *Medicare paid.*
- *Overpayment.*
- *Other commercial health or dental insurance payment.* Enter the amount paid by the other commercial health or dental insurance carrier.
- *Not our patient.*
- *Wrong date of service.*
- *Duplicate payment by Wisconsin Medicaid.*
- *Billing error.*
- *Other/Comments.* Add any clarifying information not included above.

The provider must maintain a copy of this form for his or her records.

ATTACHMENT 2
Claim Refund

(The “Claim Refund” is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13066 (07/03)

WISCONSIN MEDICAID
CLAIM REFUND

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

1. Payee / Billing Provider's Medicaid Provider Number	2. Name — Payee / Billing Provider
3. Subscriber / Recipient Medicaid Identification Number	4. Name — Subscriber / Recipient

SECTION II — CLAIM INFORMATION

5. Payer Control Number / Internal Control Number	6. Check Issue Date / Report Date

7. Date(s) of Service From	To	8. Procedure Code / National Drug Code / Revenue Code	9. Modifiers 1-4 Mod 1	Mod 2	Mod 3	Mod 4	10. Billed Amount	11. Refund Amount
							12. Refund Total	

SECTION III — REFUND INFORMATION

13. Reason for Refund (check one)

- ❑ Medicare paid.
- ❑ Overpayment.
- ❑ Other commercial health or dental insurance payment (OI-P) $_____.
- ❑ Not our patient.
- ❑ Wrong date of service.
- ❑ Duplicate payment by Wisconsin Medicaid.
- ❑ Billing error.
- ❑ Other/Comments.

Mail this form and either the Medicaid-issued check or provider-issued refund check to

Wisconsin Medicaid
Financial Services Cash Unit
6406 Bridge Rd
Madison WI 53784-0004

Maintain a copy of this form for your records.