

To:
All Providers
HMOs and Other
Managed Care
Programs

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

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 dhfs.wisconsin.gov/medicaid/.

PHC 1250

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 02/04.

Form revised to allow for more complete information

Wisconsin Medicaid has revised the Other Coverage Discrepancy Report form to allow for more complete information to be submitted. This form is used to notify Wisconsin Medicaid of information that contradicts Wisconsin Medicaid's records on a recipient's other health care coverage (including Medicare).

Wisconsin Medicaid encourages providers to discontinue using old versions of the form and begin using the revised form, HCF 1159, dated 02/04. The revised form, which may be photocopied for future use, is included as the Attachment of this *Wisconsin Medicaid and BadgerCare Update*.

The revised form is also available in fillable Portable Document Format (PDF) on the forms page of the Medicaid Web site. To access this page:

- Go to dhfs.wisconsin.gov/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.

Once completed, the form should be printed and sent to Wisconsin Medicaid along with photocopies of current insurance cards and any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials.

For questions about the Other Coverage Discrepancy Report form or to request paper copies of the new form, call Provider Services at (800) 947-9627 or (608) 221-9883.

*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.)

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 ³/₄ 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 ³/₄ MEDICARE PART A AND B COVERAGE

Medicare / HIC Number			
<input type="checkbox"/> Add		<input type="checkbox"/> Remove	
<input type="checkbox"/> Part A Coverage	Start Date	<input type="checkbox"/> Part A Coverage	End Date
<input type="checkbox"/> Part B Coverage	Start Date	<input type="checkbox"/> Part B Coverage	End Date

SECTION III ³/₄ COMMERCIAL INSURANCE, MEDICARE SUPPLEMENTAL, AND MEDICARE MANAGED CARE COVERAGE

<input type="checkbox"/> Add	<input type="checkbox"/> HMO	<input type="checkbox"/> Medicare Managed Care
<input type="checkbox"/> Remove	<input type="checkbox"/> Medicare Supplement	<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Recipient Left HMO Service Area (If Applicable)

SECTION IV ³/₄ 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 Wisconsin Medicaid Coordination of Benefits 6406 Bridge Rd Madison WI 53784-6220	Fax to Coordination of Benefits (608) 221-4567	Comments
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(Attach additional pages if necessary.)