

Affected Programs: BadgerCare Plus, Medicaid

To: Inpatient Hospital Providers, Outpatient Hospital Providers, HMOs and Other Managed Care Programs

ForwardHealth Announces Changes to Paper and Electronic Claims Submission for Hospital Services

This *ForwardHealth Update* announces changes to paper and electronic claims submission for hospital services, effective October 2008, with the implementation of the ForwardHealth interChange system and the adoption of National Provider Identifiers.

This *Update* includes the following resources for hospital providers:

- A sample UB-04 Claim Form for inpatient hospital services with revised completion instructions.
- A sample UB-04 Claim Form for outpatient hospital services with revised completion instructions.
- A sample 1500 Health Insurance Claim Form (dated 08/05) for a telemedicine originating site fee and revised completion instructions.
- The revised Adjustment/Reconsideration Request, F-13046 (10/08), with completion instructions.

A separate *Update* will give providers a calendar of important dates related to implementation.

Information in this *Update* applies to providers who provide services for BadgerCare Plus and Wisconsin Medicaid members.

Implementation of ForwardHealth interChange

In October 2008, the Department of Health Services (DHS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS). ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with

EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization (PA) requests through the secure ForwardHealth Portal. Refer to the March 2008 *ForwardHealth Update* (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

With the implementation of the ForwardHealth interChange system, important changes will be made to paper and electronic claims submission procedures that are detailed in this *Update*. These changes are not policy or coverage related.

Providers may use any of the following methods to submit claims after the October 2008 implementation of ForwardHealth interChange:

- Electronic, using one of the following:
 - ✓ Online claim submission through the ForwardHealth Portal. This is a **new** claim submission option available with the implementation of ForwardHealth interChange.
 - ✓ Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant claim transaction submissions through Electronic Data Interchange.
 - ✓ Provider Electronic Solutions (PES) software.

- Paper, using the UB-04 Claim Form or the 1500 Health Insurance Claim Form (dated 08/05).

The PES software will be updated to accommodate changes due to ForwardHealth interChange and National Provider Identifier (NPI) implementation; a revision to the PES Manual will be furnished for PES users.

General Changes for Claims Submission

Unless otherwise indicated, the following information applies to both paper and electronic claims submission for providers who provide services for BadgerCare Plus and Wisconsin Medicaid members.

Note: Providers should only use these instructions for claims received following implementation of ForwardHealth interChange. Following these procedures prior to implementation will result in the claim being denied.

Elimination of Prior Authorization Number on Claims

Providers will no longer be required to indicate a PA number on claims. ForwardHealth’s paper Remittance Advice and the 835 Health Care Claim Payment/Advice will report to the provider the PA number used to process the claim. If a PA number is indicated on a claim, it will not be used and it will have no effect on processing the claim.

Elimination of Hospital Suffix Codes

Providers are required to indicate the hospital’s 10-digit NPI on claims. Providers will no longer indicate a two-digit suffix code with the provider number on claims for the following services:

- Acquired Immune Deficiency Syndrome (AIDS) care.
- Brain injury cases.
- Services provided at critical access hospitals.
- Ventilator-dependent care.

The July 2008 *Update* (2008-121), titled “Changes to Prior Authorization for Inpatient Hospital Services,” provides more information about PA procedures for these services

following the implementation of ForwardHealth interChange.

Elimination of M-5 Medicare Disclaimer Code

The ForwardHealth interChange system will be able to determine whether a provider is Medicare certified on the date of service (DOS). Therefore, Medicare disclaimer code “M-5” (Provider is not Medicare certified) has been eliminated. The only allowable Medicare disclaimer codes in the ForwardHealth interChange system will consist of “M-7” (Medicare disallowed or denied payment) and “M-8” (Noncovered Medicare service). Providers should note that if the “M-5” disclaimer code is indicated on the claim, the claim will be denied.

Revision of Good Faith Claims Process

A good faith claim may be submitted when a claim is denied due to a discrepancy between the member’s enrollment file and the member’s actual enrollment. If a member presents a temporary card or an Express Enrollment (EE) card, BadgerCare Plus encourages providers to check the member’s enrollment and, if the enrollment is not on file yet, make a photocopy of the member’s temporary card or EE card. If Wisconsin’s Enrollment Verification System (EVS) indicates that the member is not enrolled in BadgerCare Plus, providers should check enrollment again in two days or wait one week to submit a claim to BadgerCare Plus. If the EVS indicates that the member still is not enrolled after two days, or if the claim is denied with an enrollment-related Explanation of Benefits code, providers should contact Provider Services at (800) 947-9627 for assistance.

Elimination of Series Billing

ForwardHealth will accept multi-page claims with as many as 50 details on a 1500 Health Insurance Claim Form and 999 details on a UB-04 Claim Form; therefore, series billing (i.e., allowing providers to indicate up to four DOS per detail line) is no longer necessary and will no longer be accepted. Claims submitted with series billing will be denied. Single and range dates on claims will be accepted.

Performing Provider Changing to Rendering Provider

ForwardHealth has adopted the HIPAA term “rendering provider” in place of “performing provider” to align with HIPAA terminology.

UB-04 Claim Form Changes

Following the implementation of ForwardHealth interChange, providers will be required to use the UB-04 Claim Form with the instructions included in this *Update*. Claims received on the UB-92 Claim Form after implementation will be returned to the provider unprocessed.

Refer to Attachments 1 and 2 of this *Update* for completion instructions and a sample UB-04 Claim Form for inpatient hospital services. Refer to Attachments 3 and 4 for completion instructions and a sample UB-04 Claim Form for outpatient hospital services.

Note: Providers should only use these instructions for claims received following ForwardHealth interChange implementation. Following these procedures prior to implementation will result in the claim being denied.

Revenue Codes on UB-04 Claims

Providers are reminded that they are required to indicate a four-digit revenue code on UB-04 claims requiring a revenue code. Claims that have invalid revenue codes will be denied. Providers are reminded that revenue code “0001” will not be accepted as a valid revenue code on the UB-04 Claim Form.

Beginning with implementation, claims for transplant surgeries must include an acquisition revenue code (0800-0813, 0819) or the claim will be denied.

HCPCS Codes on Outpatient Hospital Claims

ForwardHealth requires outpatient hospital providers to indicate valid Healthcare Common Procedure Coding System (HCPCS) codes for laboratory services.

Outpatient hospital providers should verify the validity of all HCPCS codes submitted with revenue codes on the UB-04. Claims that have invalid HCPCS codes will be denied.

Entering Amounts for Covered and Noncovered Days

When entering covered or noncovered days on the UB-04 Claim Form, providers are required to indicate the number of days using two decimal places. For example, to indicate one day, providers would enter “1.00” in the value codes amount field of Form Locator(s) 39-41 a-d; to indicate 12 days, providers would enter “12.00.” Providers are required to indicate a value of “1.00” in the value code amounts field when admittance and discharge occur on the same day.

Entering Dates on UB-04 Claims

Outpatient hospital providers should enter the “from” DOS in Form Locator 45 using the MMDDYY format and enter the “to” DOS in Form Locator 49 using the DD format. Providers should no longer enter dates in Form Locator 43.

Claims submitted for inpatient hospital services should indicate DOS in Form Locator 6 only.

Valid Diagnosis Codes Required

Providers are reminded that claims submitted on the UB-04 Claim Form will be monitored for the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available will be denied.

Detail Quantity

Providers are required to enter a quantity in Form Locator 46. ForwardHealth will not assume a quantity of one if Form Locator 46 is left blank. If the detail quantity is missing in Form Locator 46 on UB-04 claims, the detail will deny.

Medicare Crossover Claims

Inpatient hospital providers should note the following changes to Medicare crossover claims:

- Remittance information for crossover claims will no longer be consolidated to a single detail.
- Adjustment/Reconsideration Requests submitted for any crossover claim must include the entire original claim.

1500 Health Insurance Claim Form Changes

Following the implementation of ForwardHealth interChange, providers will be required to use the 1500 Health Insurance Claim Form (dated 08/05) with the instructions included in this *Update*. Claims received on the CMS 1500 claim form (dated 12/90) after implementation will be returned to the provider unprocessed.

Refer to Attachments 5 and 6 for completion instructions and a sample 1500 Health Insurance Claim Form for a telemedicine originating site fee.

Note: Providers should only use these instructions for claims received following ForwardHealth interChange implementation. Following these procedures prior to implementation will result in the claim being denied.

Valid Diagnosis Codes Required

ForwardHealth will monitor claims submitted on the 1500 Health Insurance Claim Form for the most specific ICD-9-CM diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available may be denied.

Diagnosis Code Pointer Changes

ForwardHealth will accept up to eight diagnosis codes in Element 21 of the 1500 Health Insurance Claim Form. To add additional diagnosis codes in this element, providers should indicate the fifth diagnosis code between the first and

third diagnosis code blanks, the sixth diagnosis code between the second and fourth diagnosis code blanks, the seventh diagnosis code to the right of the third diagnosis code blank, and the eighth diagnosis code to the right of the fourth diagnosis code blank. Providers should not number any additional diagnosis codes.

In Element 24E of the 1500 Health Insurance Claim Form, providers may indicate up to four diagnosis pointers per detail line. Valid diagnosis pointers are digits 1 through 8; digits should not be separated by commas or spaces. Services without a diagnosis pointer will be denied.

Indicating Quantities

When indicating days or units in Element 24G, only use a decimal when billing fractions; for example, enter “1.50” to indicate one and a half units. For whole units, simply enter the number; for example, enter “150” to indicate 150 units.

Signature and Date on Medicare Crossovers

A provider signature and date is now required on all provider-submitted claims, including all Medicare crossover claims submitted by providers on the 1500 Health Insurance Claim Form and processed after ForwardHealth interChange implementation. The words “signature on file” will no longer be acceptable. Provider-submitted crossover claims without a signature or date will be denied or be subject to recoupment.

Adjustment/Reconsideration Request Changes

Providers will be required to use the revised Adjustment/Reconsideration Request, F-13046 (10/08). The Adjustment/Reconsideration Request was revised to be able to be used by all ForwardHealth providers to request an adjustment of an allowed claim (a paid or partially paid claim). An adjustment or reconsideration request received in any other format will be returned to the provider unprocessed.

Refer to Attachments 7 and 8 for the revised Adjustment/Reconsideration Request Completion

Instructions, F-13046A (10/08), and the Adjustment/Reconsideration Request.

Information Regarding Managed Care

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at dhs.wisconsin.gov/forwardhealth/.

P-1250

ATTACHMENT 1

UB-04 (CMS 1450) Claim Form Completion

Instructions for Inpatient Hospital Services

Effective for claims received on and after implementation of ForwardHealth interChange.

Use the following claim form completion instructions, *not* the form locator descriptions printed on the claim form, to avoid claim denial or inaccurate claim payment. Complete all form locators unless otherwise indicated. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-04 claim for ForwardHealth. For complete billing instructions, refer to the National UB-04 Uniform Billing Manual prepared by the National Uniform Billing Committee (NUBC). The National UB-04 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-04 Uniform Billing Manual by calling (312) 422-3390 or by accessing the NUBC Web site at www.nubc.org/.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at www.forwardhealth.wi.gov/ for more information about verifying enrollment.

Note: Each provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to ForwardHealth.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the hospital submitting the claim and the hospital's complete mailing address. The minimum requirement is the hospital's name, city, state, and ZIP+4 code. The name in Form Locator 1 should correspond with the National Provider Identifier (NPI) in Form Locator 56.

Form Locator 2 — Pay-to Name, Address, and ID (not required)

Form Locator 3a — Pat. Cntl # (optional)

Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance Advice (RA) and/or the 835 Health Care Claim Payment/Advice (835) transaction.

Form Locator 3b — Med. Rec. #

Enter the number assigned to the patient's medical/health record by the provider. This number will appear on the RA and/or the 835 transaction.

Form Locator 4 — Type of Bill

Exclude the leading zero and enter the three-digit type of bill code. The type of bill codes for inpatient hospital services include the following:

- 111 = Hospital, inpatient, admit through discharge claim.
- 851 = Special facility, critical access hospital, admit through discharge claim.

Form Locator 5 — Fed. Tax No.

Data are required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider's computer software is acceptable data for this element. If computer software does not automatically complete this element, enter information such as the provider's federal tax identification number.

Form Locator 6 — Statement Covers Period (From - Through)

Enter both dates in MM/DD/YY format (e.g., November 3, 2008, would be 11/03/08). Include the date of discharge or death.

Form Locator 7 — Unlabeled Field (not required)**Form Locator 8 a-b — Patient Name**

Enter the member's last name and first name, separated by a space or comma, in Form Locator 8b. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Form Locator 9 a-e — Patient Address

Data are required in this element for OCR processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "On file"). If computer software does not automatically complete this element, enter information such as the member's complete address in field 9a.

Form Locator 10 — Birthdate

Enter the member's birth date in MMDDCCYY format (e.g., September 25, 1975, would be 09251975).

Form Locator 11 — Sex (not required)**Form Locator 12 — Admission Date**

Enter the admission date in MM/DD/YY format (e.g., November 3, 2008, would be 11/03/08).

Form Locator 13 — Admission Hr (not required)**Form Locator 14 — Admission Type**

Enter the appropriate admission type for inpatient hospital services. Refer to the UB-04 Billing Manual for more information.

Form Locator 15 — Admission Src

Enter the code indicating the source of this admission. Refer to the UB-04 Billing Manual for more information.

Form Locator 16 — DHR (not required)**Form Locator 17 — Stat**

Enter the code indicating member status as of the "Statement Covers Period" through date from Form Locator 6. Refer to the UB-04 Billing Manual for more information.

Form Locators 18-28 — Condition Codes (required, if applicable)

Enter the code(s) identifying a condition related to this claim, if appropriate. Refer to the UB-04 Billing Manual for more information.

Form Locator 29 — ACDT State (not required)**Form Locator 30 — Unlabeled Field (not required)**

Form Locators 31-34 — Occurrence Code and Date (required, if applicable)

If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. To indicate that Medicare Part A or Part B benefits were exhausted mid-stay, enter occurrence code “C3” and the date that Medicare benefits were exhausted. All dates must be printed in the MMDDYY format. Refer to the UB-04 Billing Manual for more information.

Form Locators 35-36 — Occurrence Span Code (From - Through) (not required)**Form Locator 37 — Unlabeled Field (not required)****Form Locator 38 — Responsible Party Name and Address (not required)****Form Locators 39-41 a-d — Value Code and Amount**

Enter the applicable value code and associated amount. Enter covered days using value code “80” and enter the number of covered days in the corresponding amount field using two decimal places. (For example, to indicate one day, providers would enter “1.00;” to indicate 12 days, providers would enter “12.00.”) Enter noncovered days using value code “81” and enter the number of noncovered days in the amount field using two decimal places. Do not count the day of discharge for covered days. For noncovered days, enter the total noncovered days by the primary payer. The sum of covered days and noncovered days must equal the number of days in the “From-Through” period in Form Locator 6.

To indicate that Medicare Part A or Part B benefits were exhausted mid-stay, enter value code “AB” and the amount that Medicare allowed. Refer to the UB-04 Billing Manual for more information.

Form Locator 42 — Rev. Cd.

Enter the appropriate four-digit revenue code as defined by the NUBC that identifies a specific accommodation or ancillary service. Refer to hospital publications or the UB-04 Billing Manual for information and codes.

Form Locator 43 — Description (not required)**Form Locator 44 — HCPCS/Rate/HIPPS Code (not required)****Form Locator 45 — Serv. Date (not required)****Form Locator 46 — Serv. Units**

Enter the number of covered accommodation days or ancillary units of service for each line item. Do not count or include the day of discharge or death for accommodation codes.

Form Locator 47 — Total Charges (by Accommodation/Ancillary Code Category)

Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6.

Form Locator 48 — Non-covered Charges (not required)**Form Locator 49 — Unlabeled Field (not required)**

Detail Line 23

PAGE ___ OF ___

Enter the current page number in the first blank and the total number of pages in the second blank. This information must be included for both single- and multiple-page claims.

CREATION DATE (not required)

TOTALS

Enter the sum of all charges for the claim in this field. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim.*

Form Locator 50 A-C — Payer Name

Enter all health insurance payers here. Enter “T19” for Medicaid and the name of the commercial health insurance, if applicable. If submitting a multiple-page claim, enter health insurance payers only on the *first page* of the claim.

Form Locator 51 A-C — Health Plan ID (not required)

Form Locator 52 A-C — Rel. Info (not required)

Form Locator 53 A-C — Asg. Ben. (not required)

Form Locator 54 A-C — Prior Payments (required, if applicable)

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, “OI-P” must be indicated in Form Locator 80.) If the commercial health insurance denied the claim, enter “000.” Do **not** enter Medicare-paid amounts in this field.

If submitting a multiple-page claim, enter the amount paid by commercial health insurance only on the *first page* of the claim.

Form Locator 55 A-C — Est. Amount Due (not required)

Form Locator 56 — NPI

Enter the provider’s NPI. The NPI in Form Locator 56 should correspond with the name in Form Locator 1.

Form Locator 57 — Other Provider ID (not required)

Form Locator 58 A-C — Insured’s Name

Data are required in this element for OCR processing. Any information populated by a provider’s computer software is acceptable data for this element (e.g., “Same”). If computer software does not automatically complete this element, enter information such as the member’s last name, first name, and middle initial.

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Insured’s Unique ID

Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (not required)

Form Locator 64 A-C — Document Control Number (not required)**Form Locator 65 A-C — Employer Name (not required)****Form Locator 66 — Dx (not required)****Form Locator 67 — Prin. Diag. Cd.**

Enter the valid, most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). The principal diagnosis code selected must be the reason for admission. It should relate to one or more conditions or symptoms identified in the admission notes and/or admission work-up. Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include “E” (etiology) codes. “V” codes may be used as the principal diagnosis.

Form Locators 67A-Q — Other Diag. Codes

Enter valid, most specific ICD-9-CM diagnosis codes (up to five digits) corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Diagnoses that relate to an earlier episode and have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 68 — Unlabeled Field (not required)**Form Locator 69 — Admit Dx**

Enter a valid, most specific ICD-9-CM diagnosis code (up to five digits) provided at the time of admission as stated by the physician.

Form Locator 70 — Patient Reason Dx (not required)**Form Locator 71 — PPS Code (not required)****Form Locator 72 — ECI (not required)****Form Locator 73 — Unlabeled Field (not required)****Form Locator 74 — Principal Procedure Code and Date (required, if applicable)**

Enter the valid ICD-9-CM surgical procedure code that identifies the principal procedure performed during the period covered by this claim and the date on which the principal procedure described on the claim was performed.

Note: Most often, the principal procedure will be that procedure which is most closely related to the principal discharge diagnosis.

Form Locator 74a-e — Other Procedure Code and Date (required, if applicable)

If more than six procedures are performed, report those that are most important for the episode using the same guidelines for determining principal procedure (Form Locator 74).

Form Locator 75 — Unlabeled Field (not required)**Form Locator 76 — Attending**

Enter the attending provider’s NPI.

Form Locator 77 — Operating (not required)**Form Locators 78 and 79 — Other (not required)**

Form Locator 80 — Remarks (enter information when applicable)

Commercial Health Insurance Billing Information

Commercial health insurance coverage must be billed prior to billing ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

When the member has dental (“DEN”), Medicare Cost (“MCC”), Medicare + Choice (“MPC”) insurance only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 80.

When the member has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), vision only (“VIS”), a health maintenance organization (“HMO”), or some other (“OTH”) commercial health insurance, *and* the service requires commercial health insurance billing, then one of the following three other insurance (OI) explanation codes *must* be indicated in Form Locator 80. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to the following: <ul style="list-style-type: none">• The member denied coverage or will not cooperate.• The provider knows the service in question is not covered by the carrier.• The member’s commercial health insurance failed to respond to initial and follow-up claims.• Benefits are not assignable or cannot get assignment.• Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not submit claims to ForwardHealth for services that are included in the capitation payment.

Medicare Information

Use Form Locator 80 for Medicare information. Submit claims to Medicare before billing ForwardHealth.

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates the provider is not Medicare certified.

Note: Home health agencies, medical equipment vendors, pharmacies, and physician services providers must be Medicare certified to perform Medicare-covered services for dual eligibles.

- Medicare has allowed the charges. In this case, attach Medicare remittance information, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-7	<p>Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances.</p> <p><i>For Medicare Part A, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. <p><i>For Medicare Part B, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances.</p> <p><i>For Medicare Part A, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis). <p><i>For Medicare Part B, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Form Locator 81 a-d — CC

If the billing provider's NPI was indicated in Form Locator 56, enter the qualifier "B3" in the first field to the right of the form locator, followed by the 10-digit provider taxonomy code in the second field.

ATTACHMENT 3

UB-04 (CMS 1450) Claim Form Completion

Instructions for Outpatient Hospital Services

Effective for claims received on and after implementation of ForwardHealth interChange.

Use the following claim form completion instructions, *not* the form locator descriptions printed on the claim form, to avoid claim denial or inaccurate claim payment. Complete all form locators unless otherwise indicated. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-04 claim for ForwardHealth. For complete billing instructions, refer to the National UB-04 Uniform Billing Manual prepared by the National Uniform Billing Committee (NUBC). The National UB-04 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-04 Uniform Billing Manual by calling (312) 422-3390 or by accessing the NUBC Web site at www.nubc.org/.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at www.forwardhealth.wi.gov/ for more information about verifying enrollment.

Note: Each provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to ForwardHealth.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the hospital submitting the claim and the hospital's complete mailing address. The minimum requirement is the hospital's name, city, state, and ZIP+4 code. The name in Form Locator 1 should correspond with the National Provider Identifier (NPI) in Form Locator 56.

Form Locator 2 — Pay-to Name, Address, and ID (not required)

Form Locator 3a — Pat. Cntl # (optional)

Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance Advice (RA) and/or the 835 Health Care Claim Payment/Advice (835) transaction.

Form Locator 3b — Med. Rec. # (optional)

Enter the number assigned to the patient's medical/health record by the provider. This number will appear on the RA and/or the 835 transaction.

Form Locator 4 — Type of Bill

Exclude the leading zero and enter the three-digit type of bill code. The types of bill codes for outpatient hospital services include the following:

- 131 = Hospital, outpatient, admit through discharge claim.
- 851 = Special facility, critical access hospital, admit through discharge claim.

Form Locator 5 — Fed. Tax No.

Data are required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider's computer software is acceptable data for this element. If computer software does not automatically complete this element, enter information such as the provider's federal tax identification number.

Form Locator 6 — Statement Covers Period (From - Through)

Enter both dates in MM/DD/YY format (e.g., November 3, 2008, would be 11/03/08). Include the date of discharge or death.

Form Locator 7 — Unlabeled Field (not required)**Form Locator 8 a-b — Patient Name**

Enter the member's last name and first name, separated by a space or comma, in Form Locator 8b. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Form Locator 9 a-e — Patient Address

Data are required in this element for OCR processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "On file"). If computer software does not automatically complete this element, enter information such as the member's complete address in field 9a.

Form Locator 10 — Birthdate

Enter the member's birth date in MMDDCCYY format (e.g., September 25, 1975, would be 09251975).

Form Locator 11 — Sex (not required)**Form Locator 12 — Admission Date (not required)****Form Locator 13 — Admission Hr (not required)****Form Locator 14 — Admission Type (not required)****Form Locator 15 — Admission Src**

Enter the code indicating the source of this admission. Refer to the UB-04 Billing Manual for more information.

Form Locator 16 — DHR (not required)**Form Locator 17 — Stat (not required)****Form Locators 18-28 — Condition Codes (required, if applicable)**

Enter the code(s) identifying a condition related to this claim, if appropriate. Refer to the UB-04 Billing Manual for more information.

Form Locator 29 — ACDT State (not required)**Form Locator 30 — Unlabeled Field (not required)****Form Locators 31-34 — Occurrence Code and Date (required, if applicable)**

If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates must be printed in the MMDDYY format. Refer to the UB-04 Billing Manual for more information.

Form Locators 35-36 — Occurrence Span Code (From - Through) (not required)

Form Locator 37 — Unlabeled Field (not required)**Form Locator 38 — Responsible Party Name and Address (not required)****Form Locators 39-41 a-d — Value Code and Amount (required, if applicable)**

Enter the applicable value code and associated amount. Enter covered days using value code “80” and enter the number of covered days in the corresponding amount field using two decimal places. (For example, to indicate one day, providers would enter “1.00;” to indicate 12 days, providers would enter “12.00.”) Enter noncovered days using value code “81” and enter the number of noncovered days in the amount field using two decimal places. For noncovered days, enter the total noncovered days by the primary payer. The sum of covered days and noncovered days must equal the number of days in the “From-Through” period in Form Locator 6.

Form Locator 42 — Rev. Cd.

Enter the appropriate four-digit revenue code as defined by the NUBC that identifies a specific accommodation or ancillary service. Refer to hospital publications or the UB-04 Billing Manual for information and codes.

Form Locator 43 — Description (not required)**Form Locator 44 — HCPCS/Rate/HIPPS Code (required, if applicable)**

For outpatient laboratory services identified by revenue codes 030X and 031X and revenue codes 0923 and 0925, enter the appropriate corresponding Healthcare Common Procedure Coding System or *Current Procedural Terminology* code.

Form Locator 45 — Serv. Date

Enter the single “from” date of service (DOS) in MMDDYY format in this form locator.

Form Locator 46 — Serv. Units

Enter the number of covered accommodation days or ancillary units of service for each line item.

Form Locator 47 — Total Charges (by Accommodation/Ancillary Code Category)

Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6.

Form Locator 48 — Non-covered Charges (not required)**Form Locator 49 — Unlabeled Field**

Enter the “to” DOS in DD format.

Detail Line 23**PAGE ___ OF ___**

Enter the current page number in the first blank and the total number of pages in the second blank. This information must be included for both single- and multiple-page claims.

CREATION DATE (not required)**TOTALS**

Enter the sum of all charges for the claim in this field. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim.*

Form Locator 50 A-C — Payer Name

Enter all health insurance payers here. Enter “T19” for Wisconsin Medicaid and the name of the commercial health insurance, if applicable. If submitting a multiple-page claim, enter health insurance payers only on the *first page* of the claim.

Form Locator 51 A-C — Health Plan ID (not required)

Form Locator 52 A-C — Rel. Info (not required)

Form Locator 53 A-C — Asg. Ben. (not required)

Form Locator 54 A-C — Prior Payments (required, if applicable)

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, “OI-P” must be indicated in Form Locator 80.) If the commercial health insurance denied the claim, enter “000.” Do **not** enter Medicare-paid amounts in this field.

If submitting a multiple-page claim, enter the amount paid by commercial health insurance only on the *first page* of the claim.

Form Locator 55 A-C — Est. Amount Due (not required)

Form Locator 56 — NPI

Enter the provider’s NPI. The NPI in Form Locator 56 should correspond with the name in Form Locator 1.

Form Locator 57 — Other Provider ID (not required)

Form Locator 58 A-C — Insured’s Name

Data are required in this element for OCR processing. Any information populated by a provider’s computer software is acceptable data for this element (e.g., “Same”). If computer software does not automatically complete this element, enter information such as the member’s last name, first name, and middle initial.

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Insured’s Unique ID

Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (not required)

Form Locator 64 A-C — Document Control Number (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 — Dx (not required)

Form Locator 67 — Prin. Diag. Cd.

Enter the valid, most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). The principal diagnosis identifies the condition chiefly responsible for the patient’s visit or treatment. Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include “E” (etiology) codes. “V” codes may be used as the principal diagnosis.

Form Locators 67A-Q — Other Diag. Codes

Enter valid, most specific ICD-9-CM diagnosis codes (up to five digits) corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Diagnoses that relate to an earlier episode and have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 68 — Unlabeled Field (not required)**Form Locator 69 — Admit Dx (not required)****Form Locator 70 — Patient Reason Dx (not required)****Form Locator 71 — PPS Code (not required)****Form Locator 72 — ECI (not required)****Form Locator 73 — Unlabeled Field (not required)****Form Locator 74 — Principal Procedure Code and Date (not required)****Form Locator 74a-e — Other Procedure Code and Date (not required)****Form Locator 75 — Unlabeled Field (not required)****Form Locator 76 — Attending**

Enter the attending provider's NPI.

Form Locator 77 — Operating (not required)**Form Locators 78 and 79 — Other (not required)****Form Locator 80 — Remarks (enter information when applicable)*****Commercial Health Insurance Billing Information***

Commercial health insurance coverage must be billed prior to billing ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

When the member has dental ("DEN"), Medicare Cost ("MCC"), Medicare + Choice ("MPC") insurance only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 80.

When the member has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, *and* the service requires commercial health insurance billing, then one of the following three other insurance (OI) explanation codes *must* be indicated in Form Locator 80. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to the following: <ul style="list-style-type: none"> • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not submit claims to ForwardHealth for services that are included in the capitation payment.

Medicare Information

Use Form Locator 80 for Medicare information. Submit claims to Medicare before billing ForwardHealth.

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates the provider is not Medicare certified.

Note: Home health agencies, medical equipment vendors, pharmacies, and physician services providers must be Medicare certified to perform Medicare-covered services for dual eligibles.

- Medicare has allowed the charges. In this case, attach Medicare remittance information, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-7	<p>Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances.</p> <p><i>For Medicare Part A, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. <p><i>For Medicare Part B, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances.</p> <p><i>For Medicare Part A, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis). <p><i>For Medicare Part B, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Form Locator 81 a-d — CC

If the billing provider's NPI was indicated in Form Locator 56, enter the qualifier "B3" in the first field to the right of the form locator, followed by the 10-digit provider taxonomy code in the second field.

ATTACHMENT 4

Sample UB-04 Claim Form for Outpatient Hospital Services

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ATTACHMENT 5

1500 Health Insurance Claim Form Completion Instructions for a Telemedicine Originating Site Fee

Effective for claims received on and after implementation of ForwardHealth interChange.

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at www.forwardhealth.wi.gov/ for more information about verifying enrollment.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other

Enter "X" in the Medicaid check box.

Element 1a — Insured's ID Number

Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or Wisconsin's Enrollment Verification System (EVS) to obtain the correct member ID.

Element 2 — Patient's Name

Enter the member's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Sex

Enter the member's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/CCYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the member is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name

Data are required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

Element 5 — Patient's Address

Enter the complete address of the member's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured’s Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured’s Name

Commercial health insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

If the EVS indicates that the member has dental (“DEN”) insurance only or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the member has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), Vision only (“VIS”), a health maintenance organization (“HMO”), or some other (“OTH”) commercial health insurance, and the service requires other insurance billing, one of the following three other insurance (OI) explanation codes must be indicated in the first box of Element 9. If submitting a multiple-page claim, providers are required to indicate OI explanation codes on the *first page* of the claim.

The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following: <ul style="list-style-type: none">• The member denied coverage or will not cooperate.• The provider knows the service in question is not covered by the carrier.• The member’s commercial health insurance failed to respond to initial and follow-up claims.• Benefits are not assignable or cannot get assignment.• Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill ForwardHealth for services that are included in the capitation payment.

Element 9a — Other Insured’s Policy or Group Number (not required)

Element 9b — Other Insured’s Date of Birth, Sex (not required)

Element 9c — Employer’s Name or School Name (not required)

Element 9d — Insurance Plan Name or Program Name (not required)

Element 10a-10c — Is Patient’s Condition Related to: (not required)

Element 10d — Reserved for Local Use (not required)

Element 11 — Insured’s Policy Group or FECA Number

Use the first box of this element only. (Elements 11a, 11b, 11c, and 11d are not required.) Element 11 should be left blank when one or more of the following statements are true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does *not* have any Medicare coverage including Medicare Cost (“MCC”) or Medicare + Choice (“MPC”) for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. If submitting a multiple-page claim, indicate Medicare disclaimer codes on the *first page* of the claim. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-7	<p>Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member’s lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.</p> <p><i>For Medicare Part A, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none">• The provider is identified in ForwardHealth files as certified for Medicare Part A.• The member is eligible for Medicare Part A.• The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. <p><i>For Medicare Part B, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none">• The provider is identified in ForwardHealth files as certified for Medicare Part B.• The member is eligible for Medicare Part B.• The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance.</p> <p><i>For Medicare Part A, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none">• The provider is identified in ForwardHealth files as certified for Medicare Part A.• The member is eligible for Medicare Part A.• The service is usually covered by Medicare Part A but not in this circumstance (e.g., member’s diagnosis). <p><i>For Medicare Part B, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none">• The provider is identified in ForwardHealth files as certified for Medicare Part B.• The member is eligible for Medicare Part B.• The service is usually covered by Medicare Part B but not in this circumstance (e.g., member’s diagnosis).

Element 11a — Insured’s Date of Birth, Sex (not required)

Element 11b — Employer’s Name or School Name (not required)

Element 11c — Insurance Plan Name or Program Name (not required)

Element 11d — Is there another Health Benefit Plan? (not required)

Element 12 — Patient’s or Authorized Person’s Signature (not required)

Element 13 — Insured’s or Authorized Person’s Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Element 17 — Name of Referring Provider or Other Source (not required)

Element 17a — (not required)

Element 17b — NPI (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate “See Attachment?” in Element 19.

Element 20 — Outside Lab? \$Charges (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter a valid *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. List the primary diagnosis first. Etiology (“E”) and manifestation (“M”) codes may not be used as a primary diagnosis. The diagnosis description is not required.

ForwardHealth accepts up to eight diagnosis codes. To enter more than four diagnosis codes:

- Enter the fifth diagnosis code in the space *between* the first and third diagnosis codes.
- Enter the sixth diagnosis code in the space *between* the second and fourth diagnosis codes.
- Enter the seventh diagnosis code in the space to the right of the third diagnosis code.
- Enter the eighth diagnosis code in the space to the right of the fourth diagnosis code.

When entering fifth, sixth, seventh, and eighth diagnosis codes, do *not* number the diagnosis codes (e.g., do not include a “5.” before the fifth diagnosis code).

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24

The six service lines in Element 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

Element 24A — Date(s) of Service

Enter to and from dates of service (DOS) in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date.

If the service was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "From" DOS and the last date as the "To" DOS in MM/DD/YY or MM/DD/CCYY format.

A range of dates may be indicated only if the place of service (POS), the procedure code (and modifiers, if applicable), the charge, the units, and the rendering provider were identical for each DOS within the range.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each item used or service performed.

Element 24C — EMG

Enter a "Y" for each procedure performed as an emergency. If the procedure was not an emergency, leave this element blank.

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. ForwardHealth denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D.

Element 24E — Diagnosis Pointer

Enter the number(s) that corresponds to the appropriate ICD-9-CM diagnosis code(s) listed in Element 21. Up to four diagnosis pointers per detail may be indicated. Valid diagnosis pointers, digits 1 through 8, should *not* be separated by commas or spaces.

Element 24F — \$ Charges

Enter the total charge for each line item.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Providers are to bill ForwardHealth their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

Element 24G — Days or Units

Enter the number of days or units. Only include a decimal when billing fractions (e.g., 1.50).

Element 24H — EPSDT/Family Plan (not required)**Element 24I — ID Qual (not required)****Element 24J — Rendering Provider ID. # (not required)****Element 25 — Federal Tax ID Number (not required)****Element 26 — Patient's Account No. (not required)**

Optional — Providers may enter up to 14 characters of the patient's internal office account number. This number will appear on the Remittance Advice and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge

Enter the total charges for this claim. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter “00” in the cents area if the amount is a whole number.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. If submitting a multiple-page claim, indicate the amount paid by commercial health insurance only on the *first page* of the claim.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter “00” in the cents area if the amount is a whole number.

If a dollar amount indicated in Element 29 is greater than zero, “OI-P” must be indicated in Element 9. If the commercial health insurance denied the claim, enter “000.” Do not enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28. If submitting a multiple-page claim, enter the balance due for the claim (i.e., the sum of all details from all pages of the claim minus the amount paid by commercial insurance) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter “00” in the cents area if the amount is a whole number.

Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials

The provider or authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/CCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Service Facility Location Information (not required)

Element 32a — NPI (not required)

Element 32b — (not required)

Element 33 — Billing Provider Info & Ph #

Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code.

Element 33a — NPI

Enter the NPI of the billing provider.

Element 33b

Enter qualifier “ZZ” followed by the 10-digit provider taxonomy code. Do not include a space between the qualifier (“ZZ”) and the provider taxonomy code.

ATTACHMENT 6

Sample 1500 Health Insurance Claim Form for Telemedicine Originating Site Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MEMBER, IM A.		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST		7. INSURED'S ADDRESS (No., Street)	
CITY ANYTOWN STATE WI		CITY _____ STATE _____	
ZIP CODE 55555 TELEPHONE (Include Area Code) (XXX) XXX-XXXX		ZIP CODE _____ TELEPHONE (Include Area Code) _____	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER M-7	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 437.0 3. _____		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____	
2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER		23. PRIOR AUTHORIZATION NUMBER	
1 MM DD YY 21 Q3014 1 XXX XX 1		F. \$ CHARGES G. DAYS OR LIMITS H. FISCAL Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
2		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 1234JED	
27. ACCEPT ASSIGNMENT? (or govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXX XX 29. AMOUNT PAID \$ XXXX 30. BALANCE DUE \$ XX XX	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Provider MM/DD/YY		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED _____ DATE _____		33. BILLING PROVIDER INFO & PH # I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234	
a. NPI b. _____		a. 0222222220 b. ZZ123456789X	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

ATTACHMENT 7

Adjustment/Reconsideration Request Completion Instructions

(A copy of the “Adjustment/Reconsideration Request Completion Instructions” is located on the following pages.)

(This page was intentionally left blank.)

FORWARDHEALTH ADJUSTMENT / RECONSIDERATION REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

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

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The Adjustment/Reconsideration Request, F-13046, is used by ForwardHealth to request an adjustment of an allowed claim (a paid or partially paid claim). Providers may request an adjustment when claim data need to be changed or corrected. After the changes are made to the original claim, the adjusted claim is processed.

Providers cannot adjust a totally denied claim. A claim that was totally denied must be resubmitted after the necessary corrections have been made.

Questions about adjustments and other procedures or policies may be directed to Provider Services at (800) 947-9627.

The Adjustment/Reconsideration Request is reviewed by ForwardHealth based on the information provided. Providers may photocopy the Adjustment/Reconsideration Request for their own use. Providers should be as specific as possible when describing how the original claim is to be changed. Providers may also attach a copy of the corrected claim.

The provider is required to maintain a copy of this form for his or her records.

The provider should mail the Adjustment/Reconsideration Request to the appropriate mailing address:

BadgerCare Plus
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

WCDP
PO Box 6410
Madison WI 53716-0410

WWWP
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

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

SECTION I — BILLING PROVIDER AND MEMBER INFORMATION

Check the appropriate box to indicate the applicable program to which the adjustment request is being submitted.

Element 1 — Name — Billing Provider

Enter the billing provider's name.

Element 2 — Billing Provider's Provider ID

Enter the Provider ID of the billing provider.

Element 3 — Name — Member

Enter the complete name of the member for whom payment was received.

Element 4 — Member Identification Number

Enter the member ID.

SECTION II — CLAIM INFORMATION (Non-Pharmacy)

Element 5 — Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date

Enter the date of the remittance advice or the payment date or check issue date from the 835.

Element 6 — Internal Control Number / Payer Claim Control Number

Enter the internal control number (ICN) from the remittance advice or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the ICN assigned to the most recently processed claim or adjustment.)

Add a new service line(s).

Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

Correct detail on previously paid/allowed claim.

Check if correcting details on a previously paid or allowed claim.

Element 7 — Date(s) of Service

Enter to and from date(s) of service (DOS) in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date. If grouping services, the place of service, procedure code, charges, and rendering provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive dates. The number of days must correspond to the number of units in Element 24G of the 1500 Health Insurance Claim Form.

Element 8 — POS

Enter the appropriate two-digit POS code for each service.

Element 9 — Procedure / NDC / Revenue Code

Enter the single most appropriate procedure code. ForwardHealth will deny claims received without an appropriate procedure code, National Drug Code (NDC), or revenue code. When adjusting a detail that includes an NDC and a "J" code, providers are required to attach a paper claim form to the adjustment request and follow the claim form instructions for submitting the NDC.

Element 10 — Modifiers 1-4

Enter the appropriate modifier(s).

Element 11 — Billed Amount

Enter the total billed amount for each line item. Providers are to indicate their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

Element 12 — Unit Quantity

Enter the number of units. Only include a decimal when billing fractions (e.g., 1.50).

Element 13 — Family Planning Indicator

Enter a "Y" for each family planning procedure when applicable.

Element 14 — EMG

Emergency Indicator. Enter a "Y" for each procedure performed as an emergency. If the procedure is not an emergency, leave this element blank. Dental providers should continue to enter an "E" to indicate each procedure performed as an emergency.

Element 15 — Rendering Provider Number

Health care providers may enter their NPI and taxonomy code. Non-healthcare providers may enter their Provider ID.

SECTION II — CLAIM INFORMATION (Pharmacy)

Element 5 — Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date

Enter the date of the remittance advice or the payment date or check issue date from the 835.

Element 6 — Internal Control Number / Payer Claim Control Number

Enter the ICN from the remittance advice or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the ICN assigned to the most recently processed claim or adjustment.)

Add a new service line(s).

Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

Correct detail on previously paid/allowed claim.

Check if correcting details on a previously paid or allowed claim.

Element 7 — Date(s) of Service

Enter the date filled in MM/DD/YY or MM/DD/CCYY format for each NDC in the "From" field.

Element 8 — POS

Enter the appropriate two-digit National Council for Prescription Drug Programs (NCPDP) patient location code for each NDC billed.

Element 9 — Procedure / NDC / Revenue Code

Enter the NDC. Claims received without an appropriate NDC will be denied.

Element 10 — Modifiers 1-4

Not applicable for pharmacy claims.

Element 11 — Billed Amount

Enter the total billed amount for each line item. Providers are to indicate their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

Element 12 — Unit Quantity

Enter the metric decimal quantity in the specified unit of measure according to the ForwardHealth drug file. Quantities billed should be rounded to two decimal places (i.e., nearest hundredth).

Element 13 — Family Planning Indicator

Not applicable for pharmacy claims.

Element 14 — EMG

Not applicable for pharmacy claims.

Element 15 — Rendering Provider Number

Not applicable for pharmacy claims.

SECTION III — ADJUSTMENT INFORMATION

Note: Additional information necessary for adjustment/reconsideration of an NDC should be included in Element 16 under "Other/comments."

Element 16 — Reason for Adjustment

Check one of the following boxes indicating the provider's reason for submitting the adjustment:

- *Consultant review requested.* Indicate if there are extenuating circumstances or complicated or new procedures and attach a history and physical operative or anesthesia report.
- *Recoup entire payment.* This would include claims billed in error or completely paid by another insurance carrier.
- *Other insurance payment.* Enter the amount paid by the other insurance carrier.
- *Copayment deducted in error.* Indicate if the member was a nursing home resident on the DOS, the correct number of covered service days, or if an emergency service was provided.
- *Medicare reconsideration.* Attach both the original and the new Medicare remittance information.
- *Correct service line.* Provide specific information in the comments section or attach a corrected claim.
- *Other / comments.* Add any clarifying information not included above.*

Element 17 — Signature — Billing Provider**

Authorized signature of the billing provider.

Element 18 — Date Signed**

Use either the MM/DD/YY format or the MM/DD/CCYY format.

Element 19 — Claim Form Attached

Indicate if a corrected claim form is attached. Although this is optional, ForwardHealth encourages providers to attach a corrected claim form when adding additional service lines or correcting information from a previously adjusted claim.

* This section of the Adjustment/Reconsideration Request form should be used for any pharmacy-specific fields (e.g., prescription number) pertaining to the NDC being adjusted or added to a previously processed claim. If either the Submission Clarification Code or the Unit Dose value is being adjusted on a drug claim, both values must be indicated in the comment area, even if one is not being adjusted.

** If the date or signature is missing on the Adjustment/Reconsideration Request form, the adjustment request will be denied.

ATTACHMENT 8
Adjustment/Reconsideration Request
(for photocopying)

(A copy of the "Adjustment/Reconsideration Request" is located on the following page.)

**FORWARDHEALTH
 ADJUSTMENT / RECONSIDERATION REQUEST**

Instructions: Type or print clearly. Refer to the Adjustment/Reconsideration Request Completion Instructions, F-13046A, for information about completing this form.

SECTION I — BILLING PROVIDER AND MEMBER INFORMATION

Indicate applicable program.

BadgerCare Plus / SeniorCare / Wisconsin Medicaid WCDP WWWP

1. Name — Billing Provider	2. Billing Provider's Provider ID
3. Name — Member	4. Member Identification Number

SECTION II — CLAIM INFORMATION

5. Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date	6. Internal Control Number / Payer Claim Control Number
---	---

- Add a new service line(s) to previously paid / allowed claim (in Elements 7-15, enter information to be added).
- Correct detail on previously paid / allowed claim (in 7-12, enter information as it appears on Remittance Advice or 835).

7. Date(s) of Service		8. POS	9. Procedure / NDC / Revenue Code	10. Modifiers 1-4				11. Billed Amount	12. Unit Quantity	13. Family Planning Indicator	14. EMG	15. Rendering Provider Number
From	To			Mod 1	Mod 2	Mod 3	Mod 4					

SECTION III — ADJUSTMENT INFORMATION

16. Reason for Adjustment

- Consultant review requested.
- Recoup entire payment.
- Other insurance payment (OI-P) \$ _____.
- Copayment deducted in error Member in nursing home. Covered days ____.
- Emergency.
- Medicare reconsideration. (Attach the Medicare remittance information.)
- Correct service line. (Provide specific information in the comments section below or attach a corrected claim.)
- Other / comments.

17. SIGNATURE — Billing Provider	18. Date Signed
Mail completed form to the applicable address: BadgerCare Plus WCDP WWWP Claims and Adjustments PO Box 6410 PO Box 6645 6406 Bridge Rd Madison WI 53716-0410 Madison WI 53716-0645 Madison WI 53784-0002	19. Claim Form Attached (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> No Maintain a copy of this form for your records.

