This *ForwardHealth Update* has been revised since its original publication. Attachments 8, 9, and 10 have been revised to reflect a change to the taxonomy code qualifier in accordance with the requirements published in the National Uniform Claim Committee Manual. For an overview of the change, refer to *Update* 2012-28, "Changes to Taxonomy Code Qualifier Requirements for the Paper 1500 Health Insurance Claim Form and UB-04 Claim Form."

ForwardHealth
Wisconsin serving you

Update
September 2008

No. 2008-177

Affected Programs: Wisconsin Well Woman Program
To: All Providers

ForwardHealth Announces New Screening and Diagnostic Reporting Forms and Claims Submission Procedures for Wisconsin Well Woman Program Professional Services

This *ForwardHealth Update* announces the following new screening and diagnostic reporting forms, required with the implementation of ForwardHealth interChange, for Wisconsin Well Woman Program (WWWP) services:

- Breast and Cervical Cancer Screening Activity Report (ARF), F-44723 (10/08).
- Breast Cancer Diagnostic and Follow-Up Report (DRF), F-44724 (10/08).
- Cervical Cancer Diagnostic and Follow-Up Report (DRF), F-44729 (10/08).

This *Update* also announces new electronic claim submission procedures and revised paper claim form instructions for WWWP professional services with the implementation of the interChange system and the adoption of National Provider Identifiers. Sample 1500 Health Insurance Claim Forms are included in this *Update.*

Information in this *Update* applies to providers who render services for WWWP members.

Implementation of ForwardHealth interChange

In November 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 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 the following for the Wisconsin Well Woman Program (WWWP):

- Revised screening and diagnostic reporting forms.
- Revised paper claim form completion instructions.
- Electronic claims submission procedures.

Changes indicated in this *Update* are not policy or coverage related.

New Reporting Forms

With the implementation of interChange, the WWWP has created new screening and diagnostic reporting forms. The WWWP requires providers to submit the following forms to

report screening and diagnostic procedures for WWWP members:

- Breast and Cervical Cancer Screening Activity Report (ARF), F-44723 (10/08).
- Breast Cancer Diagnostic and Follow-Up Report (DRF), F-44724 (10/08).
- Cervical Cancer Diagnostic and Follow-Up Report (DRF), F-44729 (10/08).

Refer to Attachments 1-6 of this *Update* for copies of the forms and completion instructions. Providers may photocopy the forms and completion instructions included in this *Update*.

Submitting Forms

Screening and diagnostic reporting forms should continue to be submitted on paper to the following address:

WWWP
PO Box 6645
Madison WI 53716-0645

ForwardHealth will accept new WWWP screening and diagnostic reporting forms beginning at 8 a.m. on Monday, November 10, 2008. Older versions of WWWP screening and diagnostic reporting forms must be received by 4 p.m. on Wednesday, November 5, 2008. Older versions of these forms received after this date will be returned to the provider unprocessed.

Refer to Attachment 7 for a calendar of important dates for submitting forms.

1500 Health Insurance Claim Form Changes

Following the implementation of ForwardHealth interChange, WWWP 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 the September 2008 *Update* (2008-184), titled "New Effective Dates for ForwardHealth Implementation," for more information about effective dates for claim submissions.

Refer to Attachments 8 and 9 for completion instructions and a sample 1500 Health Insurance Claim Form for WWWP services. Attachment 10 is an example of an incorrectly completed claim form.

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 *International Classification of Diseases, Ninth Revision, Clinical Modification* 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.

Valid Place of Service Codes

Providers are required to indicate a two-digit place of service (POS) code on claims for WWWP services.

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.

Anesthesia Services

Effective with the implementation of interChange, anesthesia providers are required to indicate a quantity of "1" for one minute of anesthesia services. For example, if anesthesia services were provided for a total of 26 minutes, the provider would indicate "26" units in Element 24G on the 1500 Health Insurance Claim Form.

Refer to *Update* 2008-184 for more information about effective dates for claims for anesthesia services.

Electronic Claim Submission

Beginning with the implementation of interChange, WWWP providers will have the option to submit claims electronically. Submitting claims electronically:

- Improves cash flow.
- Offers efficient and timely payments.
- Reduces billing and processing errors.
- Reduces clerical effort.

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

- Online claim submission through the ForwardHealth Portal.
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant claim transaction submissions through Electronic Data Interchange (EDI).
- Provider Electronic Solutions (PES) software.

Claims submitted electronically will be pending for 60 days in ForwardHealth interChange until they can be matched up with the appropriate screening and diagnostic reporting form submitted on paper. Wisconsin Well Woman Program providers are not required to submit additional documentation (e.g., an attachment cover sheet) with the screening and diagnostic reporting forms.

Claims on the Portal

The Portal will offer providers a more convenient way to track the status of submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status. Providers will have the ability to search for and view the status of all of their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers will be able to correct it on the Portal and resubmit it to ForwardHealth.

Refer to the July 2008 *Update* (2008-94), titled "Introducing the ForwardHealth Portal," for more information about the features of the Portal and the September 2008 *Update* (2008-167), titled "Claims and Adjustments Using the ForwardHealth Portal," for more information about submitting claims on the Portal.

HIPAA-Compliant Claim and Remittance Transactions

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A "trading partner" is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth.
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider.

Wisconsin Well Woman Program providers should refer to the ForwardHealth companion documents for more information about electronic transactions. Companion

documents provide software firms, billing services and clearinghouses, and computer processing staff who manage the technical component (e.g., telecommunication, exchange file creation, translation) of electronic transactions with useful technical information about ForwardHealth's standards for HIPAA-compliant transactions. Companion documents include information to help trading partners to successfully exchange HIPAA-compliant electronic transactions with ForwardHealth.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. Using PES software, providers may submit HIPAA-compliant electronic claims and adjustments to ForwardHealth. The PES software cannot be used to submit claims to Medicare or commercial health insurance payers.

Provider Electronic Solutions software is available to all providers free of charge and available to download from the Portal at *www.forwardhealth.wi.gov/*. Providers may call the EDI Helpdesk at (866) 416-4979 with questions about PES.

National Provider Identifiers

With the implementation of interChange, health care providers will be required to use National Provider Identifiers (NPIs) when conducting business with ForwardHealth. This will include indicating an NPI and related data, as applicable, on all provider fields on paper and electronic claims. Refer to the August 2008 *Update* (2008-148), titled "National Provider Identifier Requirements with the Implementation of ForwardHealth interChange," for more information about NPIs.

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 11 and 12 for the revised Adjustment/Reconsideration Request Completion Instructions, F-13046A (10/08), and the Adjustment/Reconsideration Request.

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). The 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
Breast and Cervical Cancer Screening Activity Report (ARF) Completion Instructions

(A copy of the "Breast and Cervical Cancer Screening Activity Report [ARF] Completion Instructions" is located on the following pages.)

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WISCONSIN WELL WOMAN PROGRAM (WWWP)

BREAST AND CERVICAL CANCER SCREENING ACTIVITY REPORT (ARF) COMPLETION INSTRUCTIONS

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

Members of ForwardHealth 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, and address.

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 or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the service.

The use of this form is mandatory when submitting claims for Wisconsin Well Woman Program services.

For reimbursement, mail this form with the completed claim to the following address:

Wisconsin Well Woman Program
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

SECTION I — BILLING PROVIDER INFORMATION

Element 1 — Provider ID

Required. ForwardHealth providers are required to enter a National Provider Identifier (NPI). Non-healthcare providers are required to enter their Provider ID.

Element 2 — Name — Billing Provider
Enter the billing provider's name.

Element 3 — Taxonomy Code
Required. Enter the taxonomy code assigned by ForwardHealth.

Element 4 — Practice Location ZIP+4 Code
Required. Enter the complete ZIP+4 code associated with the practice service location on file with ForwardHealth.

SECTION II — MEMBER PERSONAL INFORMATION

Element 5 — Last Name — Member
Required. Enter the member's last name.

Element 6 — First Name — Member
Required. Enter the member's first name.

Element 7 — Middle Initial — Member
Not required. Enter the member's middle initial.

Element 8 — Previous Last Name — Member
Not required. Enter the member's previous last name, if applicable.

Element 9 — Member Identification Number
Required. Enter the member ID.

Element 10 — Date of Birth — Member
Required. Enter the member's date of birth in MM/DD/CCYY format.

SECTION III — BREAST AND CERVICAL SCREENING

BREAST SCREENING HISTORY

Element 11 — Previous Mammogram?
Select either "Yes," "No," or "Unknown" to reflect whether or not the member has had a previous mammogram.

Element 12 — Date of Previous Mammogram
If known, provide the date (in MM/DD/CCYY format) on which the member received her most recent mammogram.

Element 13 — Member Reports Breast Symptoms?
Check "Yes," "No," or "Unknown" regarding whether or not the member has reported breast symptoms.

CLINICAL BREAST EXAM

Element 14 — Purpose of CBE
Check whether the member's clinical breast exam (CBE) is a screening or repeat exam.

Element 15 — Date of CBE
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received the CBE.

Element 16 — Name — Rendering Provider
Enter the rendering provider's name.

Element 17 — RESULT
Required if this procedure is performed. Check one box to reflect the results of the CBE. If a shaded result is selected, follow up is required.

MAMMOGRAM

Element 18 — Indication for Initial Mammogram
Check the appropriate box to indicate reason for initial mammogram.

Element 19 — Breast Diagnostic Referral Date
Enter the date (in MM/DD/CCYY format) on which the member received the breast diagnostic referral.

Element 20 — Date of Initial Mammogram
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an initial mammogram.

Element 21 — Name — Rendering Provider
Enter the rendering provider's name.

Element 22 — RESULT
Required if this procedure is performed. Check one box to reflect the results of the mammogram. If a shaded result is selected, follow up is required.

CERVICAL SCREENING HISTORY

Element 23 — Prior Pap Test?
Select either "Yes," or "No" to reflect whether or not the member has had a prior pap test.

Element 24 — Date of Last Pap Test
If Element 23 is marked "Yes," enter the date (in MM/DD/CCYY format) on which the member received her last pap test.

PELVIC EXAM

Element 25 — Date of Pelvic Exam
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a pelvic exam.

Element 26 — Name — Rendering Provider
Enter the rendering provider's name.

Element 27 — RESULT
Required if this procedure is performed. Check one box to reflect the results of the pelvic exam. If shaded result is selected, follow up is required.

PAP TEST

Element 28 — Indication for Pap Test
Check appropriate box to indicate reason for pap test.

Element 29 — Date of Cervical Diagnostic Referral
Enter the date (in MM/DD/CCYY format) on which the member received a cervical diagnostic referral.

Element 30 — Type of Pap Test
Select whether the pap test is liquid based or conventional.

Element 31— Date of Pap Test
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a pap test.

Element 32 — Name — Rendering Provider
Enter the rendering provider's name.

Element 33 — ADEQUACY OF PAP TEST SPECIMEN
Required. Check one box to signify whether the pap test specimen is satisfactory or unsatisfactory.

Element 34 — RESULT
Required if this procedure is performed. Check one box only. If a shaded result is selected, follow up is required.

HPV TEST

The WWWP reimburses a Human Papilloma Virus (HPV) test only as an immediate follow-up to Pap Test results of ASC-US; one year to follow up to LSIL.

Element 35 — Date of HPV Test
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an HPV test.

Element 36 — Result
Required if this procedure is performed. Select the result of the member's HPV test.

BREAST FOLLOW-UP RECOMMENDATION

Element 37 — Recommendation(s)
This element is required when CBE or Mammogram sections are completed. Check all applicable boxes. Include the number of months for "Follow Routine Screening" and "Short-Term Follow up."

CERVICAL FOLLOW-UP RECOMMENDATION

Element 38 — Recommendation(s)
This element is required when the Pelvic Exam, Pap Test, or HPV Test sections are completed. Check all applicable boxes. Include the number of months for "Follow Routine Screening" and "Short-Term Follow up."

Element 39 — NOTES
Include notes, as appropriate.

ATTACHMENT 2
Breast and Cervical Cancer Screening Activity Report (ARF)

(A copy of the "Breast and Cervical Cancer Screening Activity Report [ARF]" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44723 (10/08)

STATE OF WISCONSIN
s. 255.075, Wis. Stats.

WISCONSIN WELL WOMAN PROGRAM

BREAST AND CERVICAL CANCER SCREENING ACTIVITY REPORT (ARF)

Instructions: Before completing this form, refer to the Breast and Cervical Cancer Screening Activity Report Completion Instructions, F-44723A. For reimbursement, mail the claim and this completed form to Wisconsin Well Woman Program (WWWP), P.O. Box 6645, Madison, WI 53716-0645.

SECTION I — BILLING PROVIDER INFORMATION

1. Provider ID	2. Name — Billing Provider	3. Taxonomy Code	4. Practice Location ZIP+4 Code

SECTION II — MEMBER PERSONAL INFORMATION

5. Last Name — Member	6. First Name — Member	7. Middle Initial — Member

8. Previous Last Name — Member	9. Member Identification Number	10. Date of Birth — Member (MM/DD/CCYY)

SECTION III — BREAST AND CERVICAL SCREENING

BREAST SCREENING HISTORY

11. Previous Mammogram? θ Yes θ No θ Unknown

12. Date of Previous Mammogram (MM/DD/CCYY)

13. Member Reports Breast Symptoms? θ Yes θ No θ Unknown

CLINICAL BREAST EXAM

14. Purpose of CBE (Check One Box Only) θ Screening θ Repeat

15. Date of CBE (MM/DD/CCYY)

16. Name — Rendering Provider (Print)

17. RESULT (Check One Box Only)

- θ Normal Exam
- θ Benign Finding
- θ Discrete Palpable Mass — Dx Benign
- θ Discrete Palpable Mass — Suspicious for Cancer
- θ Nipple or Areolar Scaliness
- θ Skin Dimpling or Retraction
- θ Bloody or Serous Nipple Discharge

Shading indicates additional procedures needed to complete breast cycle.

MAMMOGRAM

18. Indication for Initial Mammogram

- θ Routine Screening Mammogram
- θ Initial mammogram performed to evaluate symptoms, positive CBE result, or previous abnormal mammogram result.
- θ Initial mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation.
- θ Initial mammogram not done. Patient only received CBE, or proceeded directly for other imaging or diagnostic work-up (use Breast Cancer Diagnostic and Follow-Up Report [DRF], F-44724).

19. Date of Breast Diagnostic Referral (MM/DD/CCYY)

20. Date of Initial Mammogram (MM/DD/CCYY)

21. Name — Rendering Provider (Print)

22. RESULT (Check One Box Only)

- θ Negative (BI-RADS 1)
- θ Benign Findings (BI-RADS 2)
- θ Probably Benign — Short-Term Follow up (BI-RADS 3)
- θ Suspicious Abnormality — Consider Biopsy (BI-RADS 4)
- θ Highly Suggestive of Malignancy (BI-RADS 5)
- θ Assessment Incomplete (Findings Require Additional Evaluation) (BI-RADS 0)
- θ Film Comparison Required (BI-RADS 0)
- θ Unsatisfactory

Shading indicates additional procedures needed to complete breast cycle.

CERVICAL SCREENING HISTORY

23. Prior Pap Test? θ Yes θ No

24. Date of Last Pap Test (MM/DD/CCYY)

PELVIC EXAM

25. Date of Pelvic Exam (MM/DD/CCYY)

26. Name — Rendering Provider (Print)

27. RESULT (Check One Box Only)

- θ Normal
- θ Abnormal — Not Suspicious for Cervical Cancer
- θ Abnormal — Suspicious for Cervical Cancer

Shading indicates additional procedures needed to complete cervical cycle.

PAP TEST

28. Indication for Pap Test

- θ Routine Pap Test
- θ Patient under surveillance for a previous abnormal test.
- θ Pap test done by a non-program funded provider, patient referred in for diagnostic evaluation.
- θ Pap test not done. Patient proceeded directly for diagnostic work-up or HPV test.

29. Date of Cervical Diagnostic Referral (MM/DD/CCYY)

30. Type of Pap Test (Check One Box Only)

θ Liquid based** θ Conventional

** Reimbursed at rate of Conventional Pap Smear.

31. Date of Pap Test (MM/DD/CCYY)

32. Name — Rendering Provider (Print)

33. ADEQUACY OF PAP SMEAR SPECIMEN (Check One Box Only)

θ Satisfactory θ Unsatisfactory

34. RESULT (Check One Box Only)

- θ AGC (Abnormal Glandular Cells Including Adenocarcinomas)
- θ ASC-H (Atypical Squamous Cells [ASC-US Cannot Exclude HSIL])
- θ ASC-US (Atypical Squamous Cells Undetermined Significance)
- θ High-Grade SIL (HSIL): Moderate and Severe Dysplasia, CIS / CIN 2 / CIN 3
- θ Low-Grade SIL Including HPV Changes (LSIL: HPV, Mild Dysplasia, CIN I)
- θ Negative
- θ Squamous Cell Carcinoma

Shading indicates additional procedures needed to complete cervical cycle.

Continued

SECTION III — BREAST AND CERVICAL SCREENING (Continued)

HPV TEST

The WWWP covers HPV test only as an immediate follow-up to Pap Test results of ASC-US; one year to follow up to LSIL.

35. Date of HPV Test (MM/DD/CCYY)

36. Result (Check One Box Only)

θ Negative θ Positive

BREAST FOLLOW-UP RECOMMENDATION

37. Recommendation(s)

- θ Follow Routine Screening _____ Months
- θ Short-Term Follow up _____ Months
- θ Film Comparison to Evaluate an Assessment Incomplete Mammogram
- θ Additional Mammographic Views
- θ Ultrasound
- θ Breast Consultation
- θ Fine Needle Aspiration
- θ Biopsy

CERVICAL FOLLOW-UP RECOMMENDATION

38. Recommendations(s)

- θ Follow Routine Screening _____ Months
- θ Short-Term Follow up _____ Months
- θ HPV Test
- θ Colposcopy with Biopsy
- θ Colposcopy Without Biopsy
- θ ECC Alone
- θ Diagnostic LEEP
- θ Diagnostic Cone
- θ Endometrial Biopsy**
- θ Hysterectomy*

*** Not covered by WWWP.**

**** Only covered if Pap result is AGC.**

39. Notes

ATTACHMENT 3
Breast Cancer Diagnostic and Follow Up Report (DRF) Completion Instructions

(A copy of the "Breast Cancer Diagnostic and Follow Up Report [DRF] Completion Instructions" is located on the following pages.)

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WISCONSIN WELL WOMAN PROGRAM
BREAST CANCER DIAGNOSTIC AND FOLLOW UP REPORT (DRF) COMPLETION INSTRUCTIONS

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

Members of ForwardHealth 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 use of this form is mandatory when submitting claims for ForwardHealth.

For reimbursement, mail this form with the completed claim to the following address:

Wisconsin Well Woman Program
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

SECTION I — BILLING PROVIDER INFORMATION

Element 1 — Provider ID
Required. ForwardHealth providers are required to enter a National Provider Identifier (NPI). Non-healthcare providers are required to enter their Provider ID.

Element 2 — Name — Billing Provider
Required. Enter the billing provider's name.

Element 3 — Taxonomy Code
Required. Enter the taxonomy code assigned by ForwardHealth.

Element 4 — Practice Location ZIP+4 Code
Required. Enter the complete ZIP+4 code associated with the practice service location on file with ForwardHealth.

SECTION II — MEMBER PERSONAL INFORMATION

Element 5 — Last Name — Member
Required. Enter the member's last name.

Element 6 — First Name — Member
Required. Enter the member's first name.

Element 7 — Middle Initial — Member
Enter the member's middle initial.

Element 8 — Previous Last Name — Member
Enter the member's previous last name, if applicable.

Element 9 — Member Identification Number
Required. Enter the member ID.

Element 10 — Date of Birth
Required. Enter the member's date of birth in MM/DD/CCYY format.

SECTION III — BREAST DIAGNOSTIC PROCEDURES

ADDITIONAL MAMMOGRAPHIC VIEWS

Element 11 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a mammogram.

Element 12 — Name — Rendering Provider
Enter the name of the rendering provider.

Element 13 — RESULT
Required if this procedure is performed. Check one box only to reflect results of mammogram. If shaded result is selected, follow up is required.

BREAST CONSULTATION

Element 14 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a breast consultation.

Element 15 — Name — Rendering Provider
Enter the name of the rendering provider.

Element 16 — RESULT / RECOMMENDATION
Required if this procedure is performed. Check one box only to reflect the results of the breast consultation. If shaded result is selected, follow up is required.

BIOPSY

Element 17 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a biopsy.

Element 18 — Name — Rendering Provider
Enter the rendering provider’s name.

Element 19 — Biopsy Associated Imaging
Select either “mammogram” or “ultrasound,” if applicable.

Element 20 — RESULT
Required if this procedure is performed. Check one box only to reflect results of biopsy. If shaded result is selected, follow up is required.

FILM COMPARISON

Element 21 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a film comparison.

Element 22 — Name — Rendering Provider
Enter the rendering provider’s name.

Element 23 — RESULT
Required if this procedure is performed. Check one box only to reflect the results of the film comparison. If shaded result is selected, follow up is required.

FINE NEEDLE ASPIRATION

Element 24 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a fine needle aspiration.

Element 25 — Name — Rendering Provider
Enter the rendering provider’s name.

Element 26 — RESULT
Required if this procedure is performed. Check one box only to reflect the results of the fine needle aspiration. If shaded result is selected, follow up is required.

ULTRASOUND

Element 27 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an ultrasound.

Element 28 — Name — Rendering Provider
Enter the rendering provider's name.

Element 29 — RESULT
Required if this procedure is performed. Check one box only to reflect the results of the ultrasound. If shaded result is selected, follow up is required.

Element 30 — NOTES
Enter notes, if applicable.

Element 31 — RECOMMENDATION
This field is required if elements from Additional Mammographic Views, Breast Consultation, Biopsy, Film Comparison, Fine Needle Aspiration, or Ultrasound are completed. Check all applicable boxes.

Element 32 — STATUS OF FINAL DIAGNOSIS
Required. Select one box only to reflect the status of the member's final diagnosis.

Element 33 — FINAL DIAGNOSIS
If "complete" is checked in Element 32, this field is required. Select one box only to reflect the final diagnosis and enter the date in MM/DD/CCYY format.

Element 34 — TUMOR STAGE AND TUMOR SIZE
Check one box to reflect the stage of the member's tumor, if applicable. Enter the size of the member's tumor in centimeters.

Element 35 — TREATMENT STATUS
Check one box only to reflect the member's treatment status.

Element 36 — TREATMENT DATE
Enter date (in MM/DD/CCYY format) as applicable.

ATTACHMENT 4
Breast Cancer Diagnostic and Follow-Up Report (DRF)

(A copy of the "Breast Cancer Diagnostic and Follow-Up Report [DRF]" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44724 (10/08)

STATE OF WISCONSIN
s. 255.075, Wis. Stats.

WISCONSIN WELL WOMAN PROGRAM

BREAST CANCER DIAGNOSTIC AND FOLLOW-UP REPORT (DRF)

Instructions: Before completing this form, refer to the Breast Cancer Diagnostic and Follow-Up Report (DRF) Completion Instructions, F-44724A. For reimbursement, send the claim and this completed form to Wisconsin Well Woman Program (WWWP), P.O. Box 6645, Madison, WI 53716-0645.

SECTION I — BILLING PROVIDER INFORMATION

1. Provider ID	2. Name — Billing Provider	3. Taxonomy Code	4. Practice Location ZIP+4 Code

SECTION II — MEMBER PERSONAL INFORMATION

5. Last Name — Member	6. First Name — Member	7. Middle Initial — Member
8. Previous Last Name — Member	9. Member Identification Number	10. Date of Birth (MM/DD/CCYY)

SECTION III — BREAST DIAGNOSTIC PROCEDURES

ADDITIONAL MAMMOGRAPHIC VIEWS

11. Date Performed (MM/DD/CCYY)

12. Name — Rendering Provider (Print)

13. RESULT (Check One Box Only)
- θ Negative (BI-RADS 1)
- θ Benign Findings (BI-RADS 2)
- θ Probably Benign — Short-Term Follow up (BI-RADS 3)
- θ Suspicious Abnormality — Consider Biopsy (BI-RADS 4)
- θ Highly Suggestive of Malignancy (BI-RADS 5)
- θ Assessment Incomplete (Findings Require Additional Evaluation) (BI-RADS 0)

FILM COMPARISON

21. Date Performed (MM/DD/CCYY)

22. Name — Rendering Provider (Print)

23. RESULT (Check One Box Only)
- θ Negative (BI-RADS 1)
- θ Benign Findings (BI-RADS 2)
- θ Probably Benign — Short-Term Follow up (BI-RADS 3)
- θ Suspicious Abnormality — Consider Biopsy (BI-RADS 4)
- θ Highly Suggestive of Malignancy (BI-RADS 5)
- θ Assessment Incomplete (Findings Require Additional Evaluation) (BI-RADS 0)

BREAST CONSULTATION

14. Date Performed (MM/DD/CCYY)

15. Name — Rendering Provider (Print)

16. RESULT / RECOMMENDATION (Check One Box Only)
- θ No Intervention, Routine Follow up
- θ Short-Term Follow up
- θ Biopsy / FNA Recommended

FINE NEEDLE ASPIRATION

24. Date Performed (MM/DD/CCYY)

25. Name — Rendering Provider (Print)

26. RESULT (Check One Box Only)
- θ Not Suspicious for Cancer
- θ Suspicious for Cancer
- θ No Fluid or Tissue Obtained

BIOPSY

17. Date Performed (MM/DD/CCYY)

18. Name — Rendering Provider (Print)

19. Biopsy Associated Imaging θ Mammogram θ Ultrasound

20. RESULT (Check One Box Only)
- θ Normal Breast Tissue
- θ Other Benign Changes
- θ Atypical Hyperplasia
- θ Ductal Carcinoma in Situ (DCIS)*
- θ Lobular Carcinoma in Situ (LCIS)
- θ Invasive Breast Cancer*

**Treatment Required*

ULTRASOUND

27. Date Performed (MM/DD/CCYY)

28. Name — Rendering Provider (Print)

29. RESULT (Check One Box Only)
- θ Negative (BI-RADS 1)
- θ Benign Findings (BI-RADS 2)
- θ Probably Benign — Short-Term Follow up (BI-RADS 3)
- θ Suspicious Abnormality — Consider Biopsy (BI-RADS 4)
- θ Highly Suggestive of Malignancy (BI-RADS 5)
- θ Assessment Incomplete (Findings Require Additional Evaluation) (BI-RADS 0)

Shading indicates additional follow up required for WWWP.

30. NOTES

31. RECOMMENDATION
- θ Follow Routine Screening Schedule _____ Months
- θ Short-Term Follow up _____ Months
- θ Additional Mammographic Views
- θ Ultrasound
- θ Breast Consultation
- θ Fine Needle Aspiration
- θ Biopsy
- θ Treatment

32. STATUS OF FINAL DIAGNOSIS — Check One Box Only
- θ Complete*
- θ Pending
- θ Member Deceased
- θ Lost to Follow up
- θ Refused Work-up

*Must complete Element 33 (Final Diagnosis).

33. FINAL DIAGNOSIS (Required if "Complete" is checked in Element 32 [Status of Final Diagnosis].)
Date (MM/DD/CCYY) if any box below is checked. _____
- θ Breast Cancer Not Diagnosed
- θ Lobular Carcinoma in Situ (LCIS)
- θ Ductal Carcinoma in Situ (DCIS)*
- θ Invasive Breast Cancer**

*Complete Treatment Date and Treatment Status.
**Complete Treatment Date, Treatment Status, Tumor Size, and Tumor Size.

Continued

SECTION III — BREAST DIAGNOSTIC PROCEDURES (Continued)

34. TUMOR STAGE AND TUMOR SIZE (AJCC) — Required if invasive breast cancer.

θ Stage I θ Stage II θ Stage III θ Stage IV Tumor size _____ cm

35. TREATMENT STATUS

θ Treatment Started
θ Lost to Follow up
θ Member Deceased
θ Refused by Member
θ Alternative Treatment (e.g., homeopathic therapy, herbal medicine, etc.)

36. TREATMENT DATE (MM/DD/CCYY)

ATTACHMENT 5
Cervical Cancer Diagnostic and Follow Up Report (DRF) Completion Instructions

(A copy of the "Cervical Cancer Diagnostic and Follow Up Report [DRF] Completion Instructions" is located on the following pages.)

(This page was intentionally left blank.)

WISCONSIN WELL WOMAN PROGRAM
CERVICAL CANCER DIAGNOSTIC AND FOLLOW UP REPORT (DRF) COMPLETION INSTRUCTIONS

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

Members of ForwardHealth 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 use of this form is mandatory when submitting claims for Wisconsin Well Woman Program services.

For reimbursement, mail this completed form with the completed claim to the following address:

Wisconsin Well Woman Program
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

SECTION I – BILLING PROVIDER INFORMATION

Element 1 — Provider ID
Required. ForwardHealth providers are required to enter a National Provider Identifier (NPI). Non-healthcare providers are required to enter their Provider ID.

Element 2 — Name — Billing Provider
Required. Enter the provider's name.

Element 3 — Taxonomy Code
Required. Enter the taxonomy code assigned by ForwardHealth.

Element 4 — Practice Location ZIP+4 Code
Required. Enter the complete ZIP+4 code associated with the practice service location on file with ForwardHealth.

SECTION II — MEMBER PERSONAL INFORMATION

Element 5 — Last Name — Member
Required. Enter the member's last name.

Element 6 — First Name — Member
Required. Enter the member's first name.

Element 7 — Middle Initial — Member
Enter the member's middle initial.

Element 8 — Previous Last Name — Member
Enter the member's previous last name, if applicable.

Element 9 — Member Identification Number
Required. Enter the member ID.

Element 10 — Date of Birth
Required. Enter the member's date of birth in MM/DD/CCYY format.

SECTION III — CERVICAL DIAGNOSTIC PROCEDURES

COLPOSCOPY WITH BIOPSY / ENDOCERVICAL CURETTAGE

Element 11 — Procedure Performed
Check the appropriate box indicating whether a colposcopy with biopsy or an endocervical curettage procedure is performed.

Element 12 — Date Performed
Required if one of these procedures is performed. Enter the date (in MM/DD/CCYY format) on which the member received a colposcopy with biopsy or an endocervical curettage.

Element 13 — Name — Rendering Provider
Enter the rendering provider's name.

Element 14 — RESULT
Required if one of these procedures is performed. Select one box only to reflect the result of the member's colposcopy with biopsy or endocervical curettage. If a shaded result is selected, follow up is required.

LOOP ELECTROSURGICAL EXCISION PROCEDURE (LEEP)

Element 15 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a loop electrosurgical excision procedure (LEEP).

Element 16 — Name — Rendering Provider
Enter the rendering provider's name.

Element 17 — RESULT
Required if this procedure is performed. Select one box only to reflect the result of the member's LEEP. If a shaded result is selected, follow up is required.

ENDOMETRIAL BIOPSY

Element 18 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an endometrial biopsy.

Element 19 — Name — Rendering Provider
Enter the rendering provider's name.

Element 20 — RESULT
Required if this procedure is performed. Select one box only to reflect the result of the member's endometrial biopsy. If a shaded result is selected, follow up is required.

COLPOSCOPY WITHOUT BIOPSY

Element 21 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a colposcopy without biopsy.

Element 22 — Name — Rendering Provider
Enter the rendering provider's name.

Element 23 — RESULT
Required if this procedure is performed. Select one box only to reflect the result of the member's colposcopy without biopsy. If a shaded result is selected, follow up is required.

COLD KNIFE CONE

Element 24 — Date Performed
Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a cold knife cone.

Element 25 — Name — Rendering Provider
Enter the rendering provider's name.

Element 26 — RESULT
Required if this procedure is performed. Select one box only to reflect the result of the member's cold knife cone. If a shaded result is selected, follow up is required.

Element 27 — NOTES
Enter notes, if applicable.

Element 28 — RECOMMENDATION
This element is required if elements under Colposcopy with Biopsy/Endocervical Curettage, Loop Electrosurgical Excision Procedure (LEEP), Endometrial Biopsy, Colposcopy Without Biopsy, and/or Cold Knife Cone are completed. Check all applicable recommendations.

Element 29 — STATUS OF FINAL DIAGNOSIS
Required. Check one box only to reflect the status of the member's final diagnosis.

Element 30 — FINAL DIAGNOSIS
If "Complete" is selected in Element 29, this element is required. Select one box only to reflect the final diagnosis. Enter date in MM/DD/CCYY format.

Element 31 — TUMOR STAGE
Check one box to reflect the member's tumor stage.

Element 32 — TREATMENT STATUS
Check one box only to reflect the member's treatment status.

Element 33 — TREATMENT DATE
Enter date in MM/DD/CCYY format, as applicable.

ATTACHMENT 6
Cervical Cancer Diagnostic and Follow-Up Report (DRF)

(A copy of the "Cervical Cancer Diagnostic and Follow-Up Report [DRF]" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44729 (10/08)

STATE OF WISCONSIN
s. 255.075, Wis. Stats.

WISCONSIN WELL WOMAN PROGRAM

CERVICAL CANCER DIAGNOSTIC AND FOLLOW-UP REPORT (DRF)

Instructions: Before completing this form, refer to the Cervical Cancer Diagnostic and Follow-Up Report (DRF), F-44729A. For reimbursement, send claim plus this completed form to Wisconsin Well Woman Program (WWWP), P.O. Box 6645, Madison, WI 53716-0645.

SECTION I — BILLING PROVIDER INFORMATION

1. Provider ID	2. Name — Billing Provider	3. Taxonomy Code	4. Practice Location ZIP+4 Code

SECTION II — MEMBER PERSONAL INFORMATION

5. Last Name — Member	6. First Name — Member	7. Middle Initial — Member
8. Previous Last Name — Member	9. Member Identification Number	10. Date of Birth (MM/DD/CCYY)

SECTION III — CERVICAL DIAGNOSTIC PROCEDURES

COLPOSCOPY WITH BIOPSY / ENDOCERVICAL CURETTAGE

11. Procedure Performed (Check One Box Only)
θ Colposcopy with Biopsy θ Endocervical Curettage

12. Date Performed (MM/DD/CCYY)

13. Name — Rendering Provider (Print)

14. RESULT (Check One Box Only)
θ Negative (WNL)
θ Other Non-malignant Abnormality (HPV, Condyloma)
θ CIN 1 / Mild Dysplasia
θ CIN 2 / Moderate Dysplasia
θ CIN 3 / Severe Dysplasia / CIS
θ Invasive Squamous Cell Carcinoma
θ Adenocarcinoma

COLPOSCOPY WITHOUT BIOPSY

21. Date Performed (MM/DD/CCYY)

22. Name — Rendering Provider (Print)

23. RESULT (Check One Box Only)
θ Negative (WNL)
θ Other Abnormality
θ Inflammation / Infection / HPV Changes
θ Unsatisfactory

LOOP ELECTROSURGICAL EXCISION PROCEDURE (LEEP)

15. Date Performed (MM/DD/CCYY)

16. Name — Rendering Provider (Print)

17. RESULT (Check One Box Only)
θ Negative (WNL)
θ Other Non-Malignant Abnormality (HPV, Condyloma)
θ CIN 1 / Mild Dysplasia
θ CIN 2 / Moderate Dysplasia
θ CIN 3 / Severe Dysplasia / CIS
θ Invasive Squamous Cell Carcinoma
θ Adenocarcinoma

COLD KNIFE CONE

24. Date Performed (MM/DD/CCYY)

25. Name — Rendering Provider (Print)

26. RESULT (Check One Box Only)
θ Negative (WNL)
θ Other Non-Malignant Abnormality (HPV, Condyloma)
θ CIN 1 / Mild Dysplasia
θ CIN 2 / Moderate Dysplasia
θ CIN 3 / Severe Dysplasia / CIS
θ Invasive Squamous Cell Carcinoma
θ Adenocarcinoma

ENDOMETRIAL BIOPSY

18. Date Performed (MM/DD/CCYY)

19. Name — Rendering Provider (Print)

20. RESULT (Check One Box Only)
θ Negative / Normal Endometrium
θ Hyperplasia
θ Adenomatous Hyperplasia
θ Atypical Adenomatous Hyperplasia
θ Adenocarcinoma In-situ
θ Adenocarcinoma

27. NOTES

Shading indicates follow up required for WWWP.

28. RECOMMENDATION
θ Follow Routine Screening Schedule _____ Months
θ Short Term Follow up _____ Months
θ Further Diagnostic Work Up
θ Treatment*

*Not covered by WWWP.

Continued

SECTION III — CERVICAL DIAGNOSTIC PROCEDURES (Continued)

29. STATUS OF FINAL DIAGNOSIS (Check One Box Only)

θ Complete* θ Pending θ Member Deceased θ Lost to Follow up θ Refused Work-up

*Must complete Element 30 (Final Diagnosis).

30. FINAL DIAGNOSIS (Required)

Date (MM/DD/CCYY) _____

θ Normal / Benign / Inflammation θ HPV / Condyloma / Atypia θ CIN I / Mild Dysplasia

θ CIN 2 / Moderate Dysplasia* θ CIN 3 / Severe Dysplasia / CIS* θ Invasive Cervical Cancer**

θ Adenocarcinoma of the cervix** θ LSIL (Biopsy Diagnosis) θ HSIL (Biopsy Diagnosis)*

*Complete Treatment Date and Treatment Status. **Complete Treatment Date, Treatment Status, and Tumor Stage.

31. TUMOR STAGE (AJCC)

θ Stage I θ Stage II θ Stage III θ Stage IV

32. TREATMENT STATUS — REQUIRED (Check One Box Only)

θ Treatment Started
θ Refused by Member
θ Lost to Follow up
θ Not Indicated / Not Needed
θ Member Deceased
θ Alternative Treatment (e.g., homeopathic therapy, herbal medicine, etc.)

33. TREATMENT DATE (MM/DD/CCYY)

ATTACHMENT 7
Calendar of ForwardHealth interChange Implementation Dates

Dates provided below are based on the implementation of ForwardHealth interChange on Monday, November 10, 2008.

October/November 2008						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
19 (October)	20	21	22	23	24 Last day ForwardHealth will accept from Medicaid, WCDP[1], and WWWP[2] providers paper claims completed using current claim instructions.	25
26	27 ForwardHealth will begin accepting from Medicaid, WCDP, and WWWP providers paper claim forms completed using implementation claim instructions.	28	29	30	31 Deadline for accepting all current prior authorization (PA) forms (except PA/BMNA[3]) via fax or mail — 1:00 p.m.	1 (November)
2	3 Deadline for accepting all electronic claim transactions from WWWP providers — 4:00 p.m. First day ForwardHealth will accept revised PA forms via mail. (Date stamped but not processed until November 10, 2008.)	4 Deadline for accepting all electronic claim transactions, including Point-of-Sale (POS), from WCDP providers — 4:00 p.m.	5 Deadline for accepting current screening and diagnostic reporting forms from WWWP providers — 4:00 p.m.	6	7 Deadline for accepting all electronic claim transactions, except POS, from Medicaid providers — 4:00 p.m. Deadline for accepting POS transactions from Medicaid providers — 8:00 p.m. Deadline for current STAT-PA[4] — 8:00 p.m.	8 New STAT-PA for drugs and POS available for Medicaid and WCDP pharmacies — 8:00 a.m. to 8:00 p.m.
9 New STAT-PA for drugs and POS again available for Medicaid and WCDP pharmacies — 8:00 a.m.	10 837 Health Care Claims, Provider Electronic Solutions (PES), and Portal are all available for Medicaid, WCDP, and WWWP providers for processing claims in interChange — 8:00 a.m. PA requests on the Portal now available — 8:00 a.m.	11	12	13	14	15

[1] WCDP: Wisconsin Chronic Disease Program.
[2] WWWP: Wisconsin Well Woman Program.
[3] PA/BMNA: Prior Authorization/Brand Medically Necessary Attachment, HCF 11083 (dated 07/08).
[4] STAT-PA: Specialized Transmission Approval Technology-Prior Authorization.

ATTACHMENT 8
1500 Health Insurance Claim Form Completion Instructions for Wisconsin Well Woman Program Services

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. Be advised that every code used, even if it is entered in a non-required element, is required to be a valid code. Do not include attachments unless instructed to do so.

Members enrolled in the Wisconsin Well Woman Program (WWWP) members receive a WWWP 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.

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:

WWWP
PO Box 6645
Madison WI 53716-0645

Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other
Enter "X" in the Other check box.

Element 1a — Insured's ID Number
Enter the member identification number. Do not enter any other numbers or letters. Use the WWWP 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 WWWP 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 MMDDYY format (e.g., February 3, 1955, would be 020355) or in MMDDCCYY format (e.g., February 3, 1955, would be 02031955). Place an "X" in the box next to "female."

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, is enrolled in a Medicare Advantage Plan only, or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the member has any other 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: • 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 (not required)

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 MMDDYY or MMDDCCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date.

Element 24B — Place of Service
Enter the appropriate two-digit place of service code for each item used or service performed.

Element 24C — EMG (not required)

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 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 WWWP benefits.

Element 24G — Days or Units
Enter the number of days or units. Only include a decimal when billing fractions (e.g., 1.00).

Element 24H — EPSDT/Family Plan (not required)

Element 24I — ID Qual
If the rendering provider's NPI is different than the billing provider number in Element 33A, enter a qualifier of "ZZ," indicating provider taxonomy, in the *shaded area* of the detail line.

If the rendering provider is exempt from the NPI requirement, enter a qualifier of "1D," indicating provider number.

Element 24J — Rendering Provider ID.
If the rendering provider's NPI is different than the billing provider number in Element 33A, enter the rendering provider's 10-digit taxonomy code in the *shaded area* of this element and enter the rendering provider's NPI in the *white area* provided for the NPI.

If the rendering provider is exempt from the NPI requirement, enter the provider number in the *shaded area* of this element.

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 MMDDYY or MMDDCCYY 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. Do not enter a Post Office Box or a ZIP+4 code associated with a PO Box. The practice location address entered must correspond with the NPI listed in Element 33a and match the practice location address on the provider's file maintained by ForwardHealth.

Element 33a — NPI
Enter the NPI of the billing provider.

Element 33b
Enter qualifier "ZZ" followed by the appropriate 10-digit provider taxonomy code on file with ForwardHealth.

Do not include a space between the qualifier ("ZZ") and the provider taxonomy code.

ATTACHMENT 9

Sample 1500 Health Insurance Claim Form for Wisconsin Well Woman Program Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

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: MM DD YY SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (444) 444-4444

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 793 . 89
2. _____ . _____
3. _____ . _____
4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1														ZZ	987654321X
1	10	10	11			11		19103		1	XXX XX	1		NPI	0111111110
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? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ XXX XX

30. BALANCE DUE: $ XXX 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 SIGNED 11302011 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

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 10

Sample of an Incorrectly Completed 1500 Health Insurance Claim Form for Wisconsin Well Woman Program Services

Information circled in the sample claim form below is either incomplete, incorrect, or required by the Wisconsin Well Woman Program (WWWP). The procedure code indicacted in Element 24D is not a WWWP covered services.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A

3. PATIENT'S BIRTH DATE MM DD YY SEX: MM DD YY M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (444) 444-4444

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 640 . 93
2. 659 . 73
3. .
4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 MM DD YY	22		76805		1, 2	XXX XX	1		ZZ NPI	987654321X 0111111110
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? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ XX XX

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. Provide SIGNED MMDDCCYY DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

ATTACHMENT 11
Adjustment/Reconsideration Request Completion Instructions

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

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 12
Adjustment/Reconsideration Request

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

DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Health Care Access and Accountability
F-13046 (10/08)

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.

θ BadgerCare Plus / SeniorCare / Wisconsin Medicaid θ WCDP θ 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

θ Add a new service line(s) to previously paid / allowed claim (in Elements 7-15, enter information to be added).

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

SECTION III — ADJUSTMENT INFORMATION

16. Reason for Adjustment

θ Consultant review requested.

θ Recoup entire payment.

θ Other insurance payment (OI-P) **$**_____.

θ Copayment deducted in error ❑ Member in nursing home. ❑ Covered days _____. ❑ Emergency.

θ Medicare reconsideration. (Attach the Medicare remittance information.)

θ Correct service line. (Provide specific information in the comments section below or attach a corrected claim.)

θ Other / comments.

17. **SIGNATURE** — Billing Provider	18. Date Signed
Mail completed form to the applicable 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	19. Claim Form Attached (Optional) ❑ Yes ❑ No Maintain a copy of this form for your records.