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 Billing 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. 2008-178

Affected Program: Wisconsin Well Woman Program
To: All Providers

ForwardHealth Announces New Screening and Diagnostic Reporting Forms and Claims Submission Procedures for Wisconsin Well Woman Program Services (UB-04)

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 institutional services with the implementation of the interChange system and the adoption of National Provider Identifiers. Sample UB-04 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.

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 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 UB-04 Claim Form for WWWP services. Attachment 10 is a sample 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.

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.

Entering Dates on UB-04 Claims

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.

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 Disease, 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.

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

STATE OF WISCONSIN
s. 255.075, Wis. Stats.

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

STATE OF WISCONSIN
s. 255.075, Wis. Stats

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.)

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

STATE OF WISCONSIN
s. 255.075, Wis. Stats.

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
UB-04 (CMS 1450) 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 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 Wisconsin Well Woman Program (WWWP). 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 the 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.

Note: Every code used on this claim form, even if the code is entered in a non-required form locator, is required to be a valid code. In addition, 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:

WWWP
PO Box 6645
Madison WI 53716-0645

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

Enter the name of the provider submitting the claim and the provider's practice location address. The minimum requirement is the provider's name, city, state, and ZIP+4 code. Do not enter a Post Office Box or a ZIP+4 code associated with a PO Box. The name in Form Locator 1 must correspond with the 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 first digit identifies the type of facility. The second digit classifies the type of care. The third digit ("X") indicates the billing frequency; providers should enter one of the following for "X":

- 1 = Admit through discharge claim.
- 2 = Interim — first claim.
- 3 = Interim — continuing claim.
- 4 = Interim — final 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 MMDDYY format (e.g., November 1, 2006, would be 110106). Include the date of discharge or death.

Form Locator 7 — Unlabeled Field (not required)

Form Locator 8a-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 WWWP card and the EVS do not match, use the spelling from the EVS.

Form Locator 9a-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

Form Locator 12 — Admission/Start of Care Date

Enter the admission date in MMDDYY format (e.g., November 1, 2001, would be 110101).

Form Locator 13 — Admission Hr (not required)

Form Locator 14 — Priority (Type) of Admission or Visit

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

Form Locator 15 — Point of Origin for Admission or Visit

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 — Patient Discharge Status

Enter the code indicating disposition or discharge status of the member at the end service for the period covered on this claim. Refer to the UB-04 Billing Manual for more information.

Form Locators 18-28 — Condition Codes (not required)

Form Locator 29 — ACDT State (not required)

Form Locator 30 — Unlabeled Field (not required)

Form Locators 31-34 — Occurrence Code and Date (not required)

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 relevant value code and associated amount, if applicable. Refer to the UB-04 Billing Manual for more information on value codes.

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.

Form Locator 43 — Description (not required)

Form Locator 44 — HCPCS/Rate/HIPPS Code (required)

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 for each line item.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field
Enter the "to" DOS in DD format only if the detail line includes a range of consecutive dates. The revenue code, procedure code, and modifiers (if applicable), the service units, and the charge must be identical for each date within the range.

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 "WWWP" for WWWP 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 National Provider Identifier (NPI). The NPI in Form Locator 56 should correspond with the name in Form Locator 1.

Form Locator 57 — Other Provider ID (not required)
Enter the provider number in this element. The provider number in Form Locator 57 should correspond with the name in Form Locator 1.

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 WWWP 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 — Principal Diagnosis Code and Present on Admission Indicator
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). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include "E" (etiology) codes.

Form Locators 67A-Q — Other Diagnosis Codes and Present on Admission Indicator
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)
Enter a valid, most specific ICD-9-CM diagnosis code (up to five digits) provided at the time of admission.

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 (not required)

Form Locator 77 — Operating (not required)
Enter the operating provider's NPI.

Form Locators 78 and 79 — Other Provider Names and Identifiers
If a referring provider is required on the claim, enter the referring provider's NPI, followed by "DN" in the qualifier field and the last and first names of the provider in the appropriate fields. If a rendering provider is required on the claim, enter the rendering provider's NPI, followed by "82" in the qualifier field and the last and first names of the provider in the appropriate fields.

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") insurance only, is enrolled in a Medicare Advantage Plan only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 80.

When the member has any other 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: • 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.

If an Explanation of Medicare Benefits (EOMB) indicates that the member is enrolled in a Medicare Advantage Plan and the claim is being billed as a crossover, enter "MMC" in the upper right corner of the claim, indicating that the other insurance is a Medicare Advantage Plan and the claim should be processed as a crossover claim.

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	**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. *For Medicare Part A, use M-7 in the following instances (all three criteria must be met):* • 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. *For Medicare Part B, use M-7 in the following instances (all three criteria must be met):* • 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.

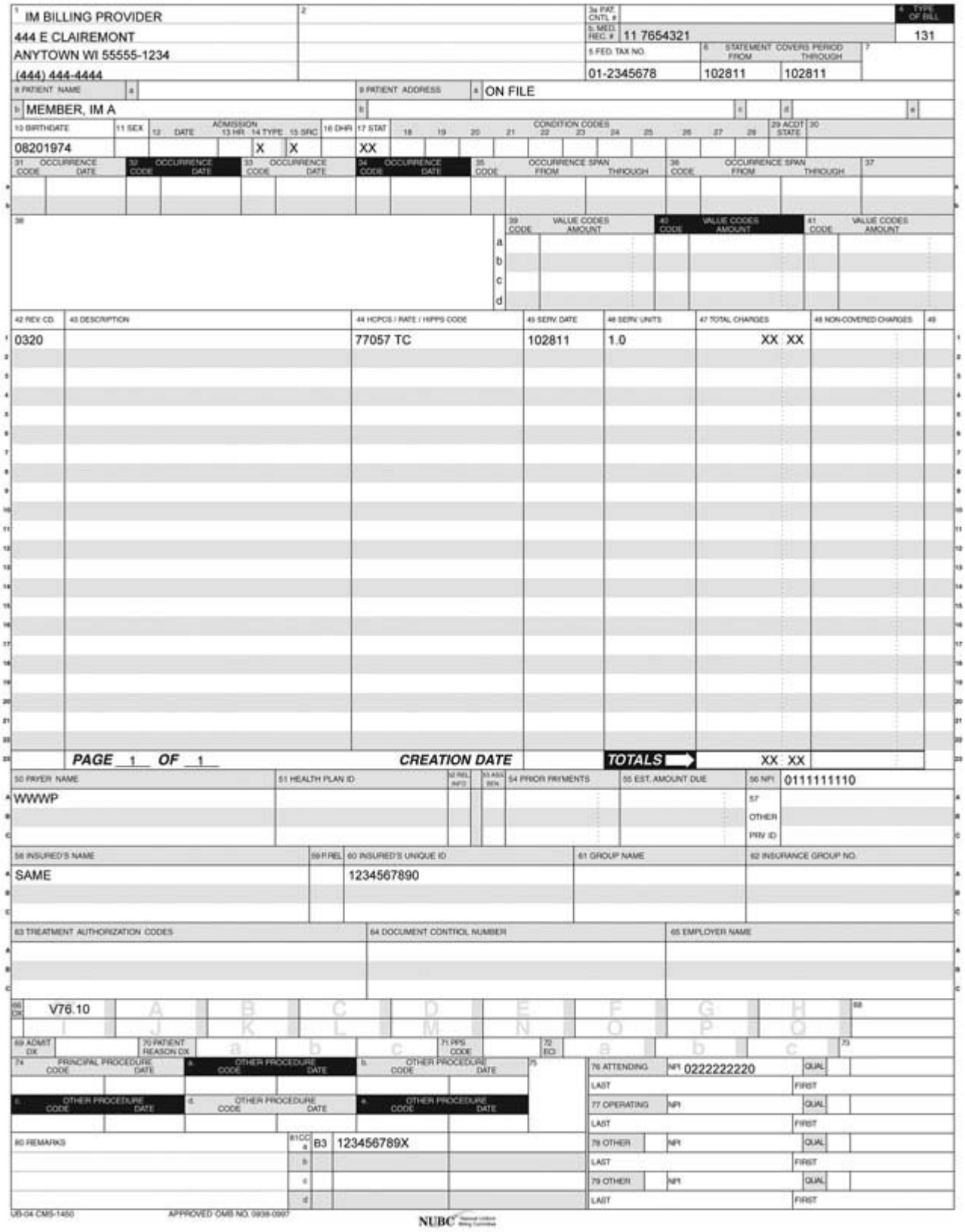
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances. *For Medicare Part A, use M-8 in the following instances (all three criteria must be met):* • The provider is identified 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). *For Medicare Part B, use M-8 in the following instances (all three criteria must be met):* • 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 (not required)

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

ATTACHMENT 9

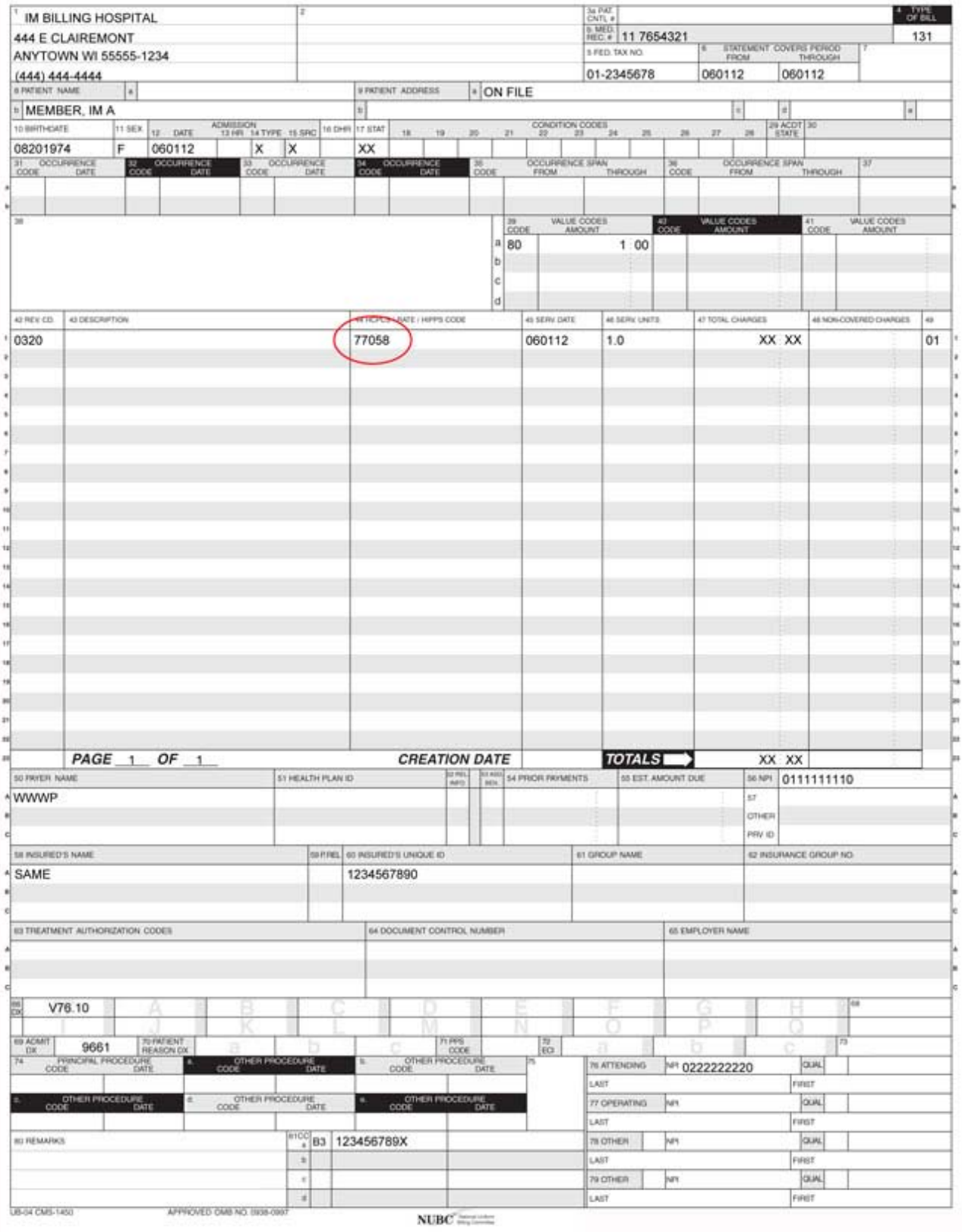
Sample UB-04 Claim Form for Wisconsin Well Woman Program Services



ATTACHMENT 10

Sample of an Incorrectly Completed UB-04 Claim Form for Wisconsin Well Woman Program Services

Information circled in the claim form below is a noncovered Wisconsin Well Woman Program service.



1 IM BILLING HOSPITAL
444 E CLAIREMONT
ANYTOWN WI 55555-1234
(444) 444-4444

3a PAT. CNTL. #
b MED. REC. # 11 7654321
4 TYPE OF BILL 131
5 FED. TAX NO. 01-2345678
6 STATEMENT COVERS PERIOD FROM 060112 THROUGH 060112
7

8 PATIENT NAME
b MEMBER, IM A
9 PATIENT ADDRESS a ON FILE

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
08201974	F	060112		X	X		XX													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	80	1 00				
b						
c						
d						

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0320		77058	060112	1.0	XX XX		01
	PAGE 1 OF 1	CREATION DATE		TOTALS	XX XX		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	0111111110
A WWWP						57 OTHER PRV ID	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO
A SAME		1234567890		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX V76.10 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
9661				

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 0222222220	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS

81CC		
a	B3	123456789X
b		
c		
d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

ATTACHMENT 11
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 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.