



**Update**

**June 2008**

**No. 2008-64**

**Affected Programs:** BadgerCare Plus, Medicaid

**To:** Federally Qualified Health Centers, Nurse Practitioners, Physician Assistants, Physician Clinics, Physicians, Rural Health Clinics, HMOs and Other Managed Care Programs

## **ForwardHealth Announces Changes to Paper and Electronic Claims Submission for Physician Services**

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

This *Update* includes sample 1500 Health Insurance Claim Forms (dated 08/05) and revised completion instructions and the revised Adjustment/Reconsideration Request, F-13046 (10/08), with completion instructions.

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

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

### **Implementation of ForwardHealth interChange**

In October 2008, the Department of Health and Family Services (DHFS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS). ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization (PA) requests through the secure ForwardHealth Portal. Refer to the

March 2008 *ForwardHealth Update* (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

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

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

- Electronic, using one of the following:
  - ✓ Online claim submission through the ForwardHealth Portal. This is a **new** claim submission option available with the implementation of ForwardHealth interChange.
  - ✓ Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant claim transaction submissions through Electronic Data Interchange.
  - ✓ Provider Electronic Solutions (PES) software.
- Paper, using the 1500 Health Insurance Claim Form (dated 08/05).

**Department of Health and Family Services**

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

### **General Changes for Claims Submission**

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

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

### ***Elimination of Prior Authorization Number on Claims***

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

### ***Elimination of M-5 Medicare Disclaimer Code***

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

### ***Revision of Good Faith Claims Process***

A good faith claim may be submitted when a claim is denied due to a discrepancy between the member's enrollment file and the member's actual enrollment. If a member presents a

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

### ***Elimination of Series Billing***

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

### ***Performing Provider Changing to Rendering Provider***

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

### ***Provider Identifiers***

A valid NPI must be indicated in instances where a referring provider is required. The claim will be denied if the referring provider's NPI is not indicated or if the NPI is invalid.

### **1500 Health Insurance Claim Form Changes**

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

Refer to Attachments 1-6 of this *Update* for completion instructions and sample 1500 Health Insurance Claim Forms for physician services.

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

### ***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.

### ***National Drug Codes Required on Claims for Outpatient Physician-Administered Drugs***

Providers will be required to comply with requirements of the federal Deficit Reduction Act of 2005 (DRA) and submit National Drug Codes (NDCs) with Healthcare Common Procedure Coding System (HCPCS) and select *Current Procedural Terminology* (CPT) procedure codes on claims for outpatient physician-administered drugs. National Drug Codes should be indicated in the shaded area of Element 24A-F for all claims submitted for outpatient physician-administered drugs. The NDC information will be used to identify the drugs and invoice a manufacturer for rebates, track utilization, and receive federal financial participation (FFP) funds. Claims will be denied if an NDC is not indicated or if the NDC indicated is incorrect or invalid.

If a provider dispenses a medication with a HCPCS or CPT procedure code that requires multiple NDCs (e.g., multiple package sizes), all of the NDCs must be indicated on the claim.

Watch for future publications for more information on NDCs for outpatient physician-administered drugs.

### ***Indicating Quantities***

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

### ***Signature and Date on Medicare Crossovers***

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

## **Adjustment/Reconsideration Request Changes**

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

Refer to Attachments 7 and 8 for the revised Adjustment/Reconsideration Request Completion Instructions, F-13046A (10/08), and the Adjustment/Reconsideration Request.

## **Information Regarding Managed Care**

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

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

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

For questions, call Provider Services at (800) 947-9627 or visit our Web site at [dhfs.wisconsin.gov/forwardhealth/](http://dhfs.wisconsin.gov/forwardhealth/).

PHC 1250

# ATTACHMENT 1

## 1500 Health Insurance Claim Form Completion Instructions for Physician Services

### Effective for claims received after the implementation of ForwardHealth interChange

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

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

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

Submit completed paper claims to the following address:

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

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

Enter "X" in the Medicaid check box.

#### **Element 1a — Insured's ID Number**

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

#### **Element 2 — Patient's Name**

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

#### **Element 3 — Patient's Birth Date, Sex**

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

#### **Element 4 — Insured's Name**

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

#### **Element 5 — Patient's Address**

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

#### **Element 6 — Patient Relationship to Insured (not required)**

## Element 7 — Insured’s Address (not required)

## Element 8 — Patient Status (not required)

## Element 9 — Other Insured’s Name

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

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

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

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

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

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

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

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

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

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

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

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

## Element 11— Insured’s Policy Group or FECA Number

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

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

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

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

## 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 (required for evaluation & management [E&M] consultations and laboratory and radiology services only)**

Enter the referring physician's name.

**Element 17a (not required)**

**Element 17b — NPI (required for E&M consultations and laboratory and radiology services only)**

Enter the National Provider Identifier (NPI) of the referring physician.

**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).

***Family Planning Services***

Indicate the appropriate ICD-9-CM diagnosis code from the V25 series for services and supplies that are only contraceptive management related.

**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-24G (shaded area)**

National Drug Codes (NDCs) must be indicated in the shaded area of Elements 24A-24G. Providers may indicate up to two NDCs per completed service line. Each NDC must be accompanied by an NDC qualifier, unit qualifier, and units. To indicate an NDC, providers should do the following:

- Indicate the NDC qualifier “N4,” followed by the 11-digit NDC, with no space in between.
- Indicate one space between the NDC and the unit qualifier.
- Indicate one unit qualifier (F2 [International unit], GR [Gram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between. The NDC units should be recorded with an implied decimal three digits from the left; for example, to indicate a unit of “1,” “1000” would be entered after the unit qualifier.
- If indicating two NDCs in a service line, separate the two “sets” of NDC data by three spaces.
- When submitting more than one NDC on a claim, providers are required to use Healthcare Common Procedure Coding System service code J3490.

For example, two NDCs indicated in the shaded area of Elements 24A-24G would look like:  
N412345678912 GR123678 N498765432198 UN67000

## **Element 24A — Date(s) of Service**

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

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

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

## **Element 24B — Place of Service**

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

## **Element 24C — EMG**

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

## **Element 24D — Procedures, Services, or Supplies**

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

### ***Modifiers***

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

## **Element 24E — Diagnosis Pointer**

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

## **Element 24F — \$ Charges**

Enter the total charge for each line item.

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

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

## **Element 24G — Days or Units**

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

### **Element 24H — EPSDT/Family Plan**

Enter a “Y” for each family planning procedure. If family planning does not apply, leave this element blank.

*Note:* Providers should *not* use this element to indicate that a service is a result of a HealthCheck referral.

### **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.

### **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.

### **Element 25 — Federal Tax ID Number (not required)**

### **Element 26 — Patient’s Account No. (not required)**

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

### **Element 27 — Accept Assignment? (not required)**

### **Element 28 — Total Charge**

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

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

### **Element 29 — Amount Paid**

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

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

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

### **Element 30 — Balance Due**

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

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

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

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

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

### **Element 32 — Service Facility Location Information (not required)**

**Element 32a — NPI (not required)**

**Element 32b (not required)**

**Element 33 — Billing Provider Info & Ph #**

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

**Element 33a — NPI**

Enter the NPI of the billing provider.

**Element 33b**

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

# ATTACHMENT 2

## Sample 1500 Health Insurance Claim Form for Physician Obstetrical Services (Antepartum Care in a Health Professional Shortage Area)

1500

### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																	
1. MEDICARE <input type="checkbox"/> (Medicare #) <b>X</b> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLX/LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567890</b>																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MEMBER, IM A.</b>					3. PATIENT'S BIRTH DATE <b>MM DD YY</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>SAME</b>																																																	
5. PATIENT'S ADDRESS (No., Street) <b>609 WILLOW ST</b>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																																																	
CITY <b>ANYTOWN</b>					STATE <b>WI</b>					CITY					STATE																																												
ZIP CODE <b>55555</b>					TELEPHONE (Include Area Code) <b>(XXX) XXX-XXXX</b>					ZIP CODE					TELEPHONE (Include Area Code) ( )																																												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-P</b>					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE					11. INSURED'S POLICY GROUP OR FECA NUMBER					12. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																												
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. AUTO ACCIDENT? PLACE (State)					b. EMPLOYER'S NAME OR SCHOOL NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME																																												
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					c. OTHER ACCIDENT?					c. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																												
c. EMPLOYER'S NAME OR SCHOOL NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																												
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																												
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 _____										SIGNED _____																																																	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																												
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____					17b. NPI _____					18. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																												
19. RESERVED FOR LOCAL USE					21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>659.80</b>					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 EMG					C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					D. DIAGNOSIS POINTER					E. \$ CHARGES					F. \$ CHARGES					G. DAYS OR UNITS					H. EPSC Family Plan					I. ID. QUM					J. RENDERING PROVIDER ID. #														
1 <b>MM DD YY</b>					<b>11</b>					<b>99204 TH AQ</b>					<b>1</b>					<b>XX XX 1</b>					<b>ZZ 123456789X</b>					<b>0111111110</b>																													
2 <b>MM DD YY</b>					<b>11</b>					<b>99213 TH AQ</b>					<b>1</b>					<b>XX XX 1</b>					<b>ZZ 123456789X</b>					<b>0111111110</b>																													
3																																																											
4																																																											
5																																																											
6																																																											
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO. <b>1234JED</b>										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ <b>XXX XX</b>										29. AMOUNT PAID \$ <b>XXXX</b>										30. BALANCE DUE \$ <b>XX XX</b>									
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.) <b>I.M. Provider MM/DD/YY</b>										32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b. <b>ZZ123456789X</b>										33. BILLING PROVIDER INFO & PH # <b>I.M. PHYSICIAN CLINIC</b> <b>1 W WILLIAMS ST</b> <b>ANYTOWN WI 55555-1234</b>																																							
SIGNED _____ DATE _____										a. <b>NPI</b> b. <b>ZZ123456789X</b>										a. <b>0222222220</b> b. <b>ZZ123456789X</b>																																							

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

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

# ATTACHMENT 3

## Sample 1500 Health Insurance Claim Form for Physician Surgical Services (Bilateral Surgery)

1500

### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <b>X</b> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK (LUNG) (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567890</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MEMBER, IM A.</b>										3. PATIENT'S BIRTH DATE MM DD YY <b>MM DD YY</b> SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) <b>609 WILLOW ST</b>										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY <b>ANYTOWN</b>					STATE <b>WI</b>					CITY					STATE				
ZIP CODE <b>55555</b>					TELEPHONE (Include Area Code) <b>(XXX) XXX-XXXX</b>					ZIP CODE					TELEPHONE (Include Area Code) ( )				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-P</b>										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
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 <b>MM DD YY</b> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>996.79</b>										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
B. PLACE OF SERVICE										23. PRIOR AUTHORIZATION NUMBER									
C. EMG										24. E. DIAGNOSIS POINTER									
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										F. \$ CHARGES									
E. DIAGNOSIS POINTER										G. DAYS OR UNITS									
H. EPSC Family Plan										I. ID. QUANT.									
J. RENDERING PROVIDER ID. #																			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. <b>1234JED</b>									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ <b>XXX XX</b>									
29. AMOUNT PAID \$ <b>XXXX</b>										30. BALANCE DUE \$ <b>XX XX</b>									
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.) <b>I.M. Provider MM/DD/YY</b>										32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH # <b>I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234</b>																			
SIGNED _____ DATE _____										a. <b>0222222220</b> b. <b>ZZ123456789X</b>									

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

# ATTACHMENT 4

## Sample 1500 Health Insurance Claim Form for Physician Radiology Services

1500

### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE <input type="checkbox"/> (Medicare #) <b>X</b> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK(LUNG) <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567890</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MEMBER, IM A.</b>		3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> SEX	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>SAME</b>		5. PATIENT'S ADDRESS (No., Street) <b>609 WILLOW ST</b>	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY STATE <b>ANYTOWN WI</b>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-P</b>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
13. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		14. EMPLOYER'S NAME OR SCHOOL NAME	
15. INSURANCE PLAN NAME OR PROGRAM NAME		16. INSURANCE PLAN NAME OR PROGRAM NAME	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			
17. 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 _____		18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____	
19. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		20. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
21. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>I.M. REFERRING PROVIDER</b>		22. NPI <b>0123456780</b>	
23. RESERVED FOR LOCAL USE		24. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
25. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		26. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		28. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
1. <b>959.09</b>		23. PRIOR AUTHORIZATION NUMBER	
2. _____		29. FEDERAL TAX I.D. NUMBER SSN/EIN	
3. _____		30. PATIENT'S ACCOUNT NO. <b>1234JED</b>	
4. _____		31. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>	
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. EPSCOT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		28. TOTAL CHARGE \$ <b>XXX XX</b> 29. AMOUNT PAID \$ <b>XXXX</b> 30. BALANCE DUE \$ <b>XX XX</b>	
1 <b>MM DD YY</b> <b>11</b> <b>70100</b> <b>26</b> <b>1</b> <b>XXX XX</b> <b>1</b> NPI		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.) <b>I.M. Provider MM/DD/YY</b>	
2 <b>MM DD YY</b> <b>11</b> <b>70100</b> <b>26</b> <b>1</b> <b>XXX XX</b> <b>1</b> NPI		32. SERVICE FACILITY LOCATION INFORMATION	
3 <b>MM DD YY</b> <b>11</b> <b>70100</b> <b>26</b> <b>1</b> <b>XXX XX</b> <b>1</b> NPI		33. BILLING PROVIDER INFO & PH # <b>I.M. PROVIDER</b> <b>1 W WILLIAMS ST</b> <b>ANYTOWN WI 55555-1234</b>	
4 <b>MM DD YY</b> <b>11</b> <b>70100</b> <b>26</b> <b>1</b> <b>XXX XX</b> <b>1</b> NPI		a. <b>0222222220</b> b. <b>ZZ123456789X</b>	
5 <b>MM DD YY</b> <b>11</b> <b>70100</b> <b>26</b> <b>1</b> <b>XXX XX</b> <b>1</b> NPI		25. FEDERAL TAX I.D. NUMBER SSN/EIN	
6 <b>MM DD YY</b> <b>11</b> <b>70100</b> <b>26</b> <b>1</b> <b>XXX XX</b> <b>1</b> NPI		26. PATIENT'S ACCOUNT NO. <b>1234JED</b>	
25. FEDERAL TAX I.D. NUMBER SSN/EIN		27. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>	
26. PATIENT'S ACCOUNT NO. <b>1234JED</b>		28. TOTAL CHARGE \$ <b>XXX XX</b> 29. AMOUNT PAID \$ <b>XXXX</b> 30. BALANCE DUE \$ <b>XX XX</b>	
27. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		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.) <b>I.M. Provider MM/DD/YY</b>	
28. TOTAL CHARGE \$ <b>XXX XX</b> 29. AMOUNT PAID \$ <b>XXXX</b> 30. BALANCE DUE \$ <b>XX XX</b>		32. SERVICE FACILITY LOCATION INFORMATION	
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.) <b>I.M. Provider MM/DD/YY</b>		33. BILLING PROVIDER INFO & PH # <b>I.M. PROVIDER</b> <b>1 W WILLIAMS ST</b> <b>ANYTOWN WI 55555-1234</b>	
SIGNED _____ DATE _____		a. <b>0222222220</b> b. <b>ZZ123456789X</b>	

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

# ATTACHMENT 5

## Sample 1500 Health Insurance Claim Form for Physician Medical Services (Three Evaluation and Management Visits with Pediatric Modifier)

1500

### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567890</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MEMBER, IM A.</b>		3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M <input type="checkbox"/> F <input checked="" type="checkbox"/> <b>MM DD YY M F</b>	
5. PATIENT'S ADDRESS (No., Street) <b>609 WILLOW ST</b>		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE <b>ANYTOWN WI</b>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-P</b>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.		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 _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>480.0</b> 3. _____ 2. _____ 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 EMG C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR LINES H. FSES Family Plan I. ID. QWL J. RENDERING PROVIDER ID. #		25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. <b>1234JED</b> 27. ACCEPT ASSIGNMENT? (or gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ <b>XXX XX</b> 29. AMOUNT PAID \$ <b>XXXX</b> 30. BALANCE DUE \$ <b>XX XX</b>	
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.) <b>I.M. Provider MM/DD/YY</b> SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # <b>I.M. PROVIDER</b> <b>1 W WILLIAMS ST</b> <b>ANYTOWN WI 55555-1234</b> a. <b>0222222220</b> b. <b>ZZ123456789X</b>	

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

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

# ATTACHMENT 6

## Sample 1500 Health Insurance Claim Form for Physician Laboratory Services

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div>											
<b>HEALTH INSURANCE CLAIM FORM</b> <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>											
<small>PICA</small>										<small>PICA</small>	
<b>1. MEDICARE</b> <input type="checkbox"/> <b>MEDICAID</b> <input checked="" type="checkbox"/> <b>TRICARE</b> <input type="checkbox"/> <b>CHAMPVA</b> <input type="checkbox"/> <b>GROUP HEALTH PLAN</b> <input type="checkbox"/> <b>FECA BLK(LUNG)</b> <input type="checkbox"/> <b>OTHER</b> <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>				<b>1a. INSURED'S I.D. NUMBER</b> (For Program in Item 1) <b>1234567890</b>							
<b>2. PATIENT'S NAME</b> (Last Name, First Name, Middle Initial) <b>MEMBER, IM A.</b>				<b>3. PATIENT'S BIRTH DATE</b> MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> <b>SEX</b>				<b>4. INSURED'S NAME</b> (Last Name, First Name, Middle Initial) <b>SAME</b>			
<b>5. PATIENT'S ADDRESS</b> (No., Street) <b>609 WILLOW ST</b>				<b>6. PATIENT RELATIONSHIP TO INSURED</b> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				<b>7. INSURED'S ADDRESS</b> (No., Street)			
<b>CITY</b> <b>ANYTOWN</b>			<b>STATE</b> <b>WI</b>			<b>CITY</b>			<b>STATE</b>		
<b>ZIP CODE</b> <b>55555</b>		<b>TELEPHONE</b> (Include Area Code) <b>(XXX) XXX-XXXX</b>		<b>Employed</b> <input type="checkbox"/> <b>Full-Time Student</b> <input type="checkbox"/> <b>Part-Time Student</b> <input type="checkbox"/>		<b>ZIP CODE</b>		<b>TELEPHONE</b> (Include Area Code)			
<b>9. OTHER INSURED'S NAME</b> (Last Name, First Name, Middle Initial) <b>OI-P</b>				<b>10. IS PATIENT'S CONDITION RELATED TO:</b>				<b>11. INSURED'S POLICY GROUP OR FECA NUMBER</b>			
<b>a. OTHER INSURED'S POLICY OR GROUP NUMBER</b>				<b>a. EMPLOYMENT?</b> (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO				<b>a. INSURED'S DATE OF BIRTH</b> MM DD YY <b>SEX</b> M <input type="checkbox"/> F <input type="checkbox"/>			
<b>b. OTHER INSURED'S DATE OF BIRTH</b> MM DD YY <b>SEX</b> M <input type="checkbox"/> F <input type="checkbox"/>				<b>b. AUTO ACCIDENT?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>PLACE</b> (State)				<b>b. EMPLOYER'S NAME OR SCHOOL NAME</b>			
<b>c. EMPLOYER'S NAME OR SCHOOL NAME</b>				<b>c. OTHER ACCIDENT?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO				<b>c. INSURANCE PLAN NAME OR PROGRAM NAME</b>			
<b>d. INSURANCE PLAN NAME OR PROGRAM NAME</b>				<b>10d. RESERVED FOR LOCAL USE</b>				<b>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>			
<small>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</small>											
<b>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</b> 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 _____						<b>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</b> I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____					
<b>14. DATE OF CURRENT:</b> MM DD YY <b>ILLNESS</b> (First symptom) OR <b>INJURY</b> (Accident) OR <b>PREGNANCY</b> (LMP)				<b>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.</b> GIVE FIRST DATE MM DD YY				<b>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</b> FROM MM DD YY TO MM DD YY			
<b>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</b> <b>I.M. REFERRING PROVIDER</b>				<b>17a.</b>				<b>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</b> FROM MM DD YY TO MM DD YY			
<b>17b. NPI</b> <b>0123456780</b>								<b>20. OUTSIDE LAB?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>\$ CHARGES</b>			
<b>19. RESERVED FOR LOCAL USE</b>								<b>22. MEDICAID RESUBMISSION CODE</b> <b>ORIGINAL REF. NO.</b>			
<b>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</b> (Relate Items 1, 2, 3 or 4 to Item 24E by Line)								<b>23. PRIOR AUTHORIZATION NUMBER</b>			
<b>1. V79.9</b>				<b>3.</b>							
<b>2. V18.3</b>				<b>4.</b>							
<b>24. A. DATE(S) OF SERVICE</b> From MM DD YY To MM DD YY		<b>B. PLACE OF SERVICE</b>	<b>C. EMG</b>	<b>D. PROCEDURES, SERVICES, OR SUPPLIES</b> <small>(Explain Unusual Circumstances)</small>		<b>E. DIAGNOSIS POINTER</b>	<b>F. \$ CHARGES</b>	<b>G. DAYS OR LIMITS</b>	<b>H. EPSC/ Family Plan</b>	<b>I. ID. QWL</b>	<b>J. RENDERING PROVIDER ID. #</b>
<b>MM DD YY</b>		<b>11</b>		<b>85576 26</b>		<b>1</b>	<b>XXX XX 1</b>				
2											
3											
4											
5											
6											
<b>25. FEDERAL TAX I.D. NUMBER</b> <b>SSN EIN</b>		<b>26. PATIENT'S ACCOUNT NO.</b>		<b>27. ACCEPT ASSIGNMENT?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>28. TOTAL CHARGE</b> \$ <b>XXX XX</b>		<b>29. AMOUNT PAID</b> \$ <b>XXXX</b>		<b>30. BALANCE DUE</b> \$ <b>XX XX</b>	
<b>31. SIGNATURE OF PHYSICIAN OR SUPPLIER</b> INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small> <b>I.M. Provider MM/DD/YY</b>		<b>32. SERVICE FACILITY LOCATION INFORMATION</b>				<b>33. BILLING PROVIDER INFO &amp; PH #</b> <b>I.M. PHYSICIAN</b> <b>1 W WILLIAMS ST</b> <b>ANYTOWN WI 55555-1234</b>					
SIGNED _____ DATE _____						<b>a. 0222222220 b. ZZ123456789X</b>					

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



# **ATTACHMENT 7**

## **Adjustment/Reconsideration Request Completion Instructions**

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

(This page was intentionally left blank.)

## FORWARDHEALTH ADJUSTMENT / RECONSIDERATION REQUEST COMPLETION INSTRUCTIONS

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

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

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

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

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

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

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

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

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

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

WCDP  
PO Box 6410  
Madison WI 53716-0410

WWWP  
PO Box 6645  
Madison WI 53716-0645

### INSTRUCTIONS

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

#### SECTION I — BILLING PROVIDER AND MEMBER INFORMATION

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

##### Element 1 — Name — Billing Provider

Enter the billing provider's name.

##### Element 2 — Billing Provider's Provider ID

Enter the Provider ID of the billing provider.

##### Element 3 — Name — Member

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

##### Element 4 — Member Identification Number

Enter the member ID.

**SECTION II — CLAIM INFORMATION (Non-Pharmacy)**

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

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

**Element 6 — Internal Control Number / Payer Claim Control Number**

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

**Add a new service line(s).**

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

**Correct detail on previously paid/allowed claim.**

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

**Element 7 — Date(s) of Service**

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

**Element 8 — POS**

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

**Element 9 — Procedure / NDC / Revenue Code**

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

**Element 10 — Modifiers 1-4**

Enter the appropriate modifier(s).

**Element 11 — Billed Amount**

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

**Element 12 — Unit Quantity**

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

**Element 13 — Family Planning Indicator**

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

**Element 14 — EMG**

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

**Element 15 — Rendering Provider Number**

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

**SECTION II — CLAIM INFORMATION (Pharmacy)**

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

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

**Element 6 — Internal Control Number / Payer Claim Control Number**

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

**Add a new service line(s).**

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

**Correct detail on previously paid/allowed claim.**

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

**Element 7 — Date(s) of Service**

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

**Element 8 — POS**

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

**Element 9 — Procedure / NDC / Revenue Code**

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

**Element 10 — Modifiers 1-4**

Not applicable for pharmacy claims.

**Element 11 — Billed Amount**

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

**Element 12 — Unit Quantity**

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

**Element 13 — Family Planning Indicator**

Not applicable for pharmacy claims.

**Element 14 — EMG**

Not applicable for pharmacy claims.

**Element 15 — Rendering Provider Number**

Not applicable for pharmacy claims.

**SECTION III — ADJUSTMENT INFORMATION**

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

**Element 16 — Reason for Adjustment**

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

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

**Element 17 — Signature — Billing Provider\*\***

Authorized signature of the billing provider.

**Element 18 — Date Signed\*\***

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

**Element 19 — Claim Form Attached**

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

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

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

**ATTACHMENT 8**  
**Adjustment/Reconsideration Request**  
**(for photocopying)**

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

**FORWARDHEALTH  
 ADJUSTMENT / RECONSIDERATION REQUEST**

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

**SECTION I — BILLING PROVIDER AND MEMBER INFORMATION**

Indicate applicable program.

- BadgerCare Plus/SeniorCare/Wisconsin Medicaid       WCDP       WWWP

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

**SECTION II — CLAIM INFORMATION**

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

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

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

**SECTION III — ADJUSTMENT INFORMATION**

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

17. <b>SIGNATURE</b> — Billing Provider	18. Date Signed												
Mail completed form to the applicable address: <table style="width:100%; border: none;"> <tr> <td style="width:33%;">BadgerCare Plus</td> <td style="width:33%;">WCDP</td> <td style="width:33%;">WWWP</td> </tr> <tr> <td>Claims and Adjustments</td> <td>PO Box 6410</td> <td>PO Box 6645</td> </tr> <tr> <td>6406 Bridge Rd</td> <td>Madison WI 53716-0410</td> <td>Madison WI 53716-0645</td> </tr> <tr> <td>Madison WI 53784-0002</td> <td></td> <td></td> </tr> </table>	BadgerCare Plus	WCDP	WWWP	Claims and Adjustments	PO Box 6410	PO Box 6645	6406 Bridge Rd	Madison WI 53716-0410	Madison WI 53716-0645	Madison WI 53784-0002			19. Claim Form Attached (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> Maintain a copy of this form for your records.
BadgerCare Plus	WCDP	WWWP											
Claims and Adjustments	PO Box 6410	PO Box 6645											
6406 Bridge Rd	Madison WI 53716-0410	Madison WI 53716-0645											
Madison WI 53784-0002													

