ForwardHealth
Wisconsin serving you

Update
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Affected Programs: Wisconsin AIDS/HIV Drug Assistance Program
To: Pharmacies, HMOs and Other Managed Care Programs

Implementation of ForwardHealth interChange for the Wisconsin AIDS/HIV Drug Assistance Program

Beginning November 12, 2012, claims for Wisconsin AIDS/HIV Drug Assistance Program (ADAP) services must be submitted to ForwardHealth. Claims should no longer be submitted to ADAP. This *ForwardHealth Update* describes new policies, procedures, and claim submission instructions for ADAP.

ForwardHealth interChange

Beginning November 12, 2012, the Wisconsin AIDS/HIV Drug Assistance Program (ADAP) within the Division of Public Health will begin using the ForwardHealth interChange system to conduct business electronically, particularly to process and reimburse ADAP claims. ForwardHealth interChange, Wisconsin's Medicaid Management Information System, will allow ADAP providers more efficient methods in which to conduct business, such as the ability to submit, adjust, and correct claims electronically and view Remittance Advices (RAs) online through the secure ForwardHealth Portal at *www.forwardhealth.wi.gov/*. Claims previously submitted to ADAP for dates of service (DOS) on and after July 1, 2010, will be converted and will be available in interChange.

Authorized by s. 49.686, Wis. Stats., Wisconsin ADAP is designed to maintain the health and independence of persons living with human immunodeficiency virus (HIV) infection in Wisconsin by providing access to antiretroviral drugs, prophylactic medications, and vaccines for hepatitis A and B.

With the transition to interChange, important changes will be made to paper and electronic claim submission procedures that are detailed in this *ForwardHealth Update*.

Policies included in this *Update* are specific to ADAP. Information about ADAP will be added to the Online Handbook on the Portal in the future. The Online Handbook allows providers to access all policy and billing information in one centralized place. Providers should review the ADAP program area of the Online Handbook, when available, for complete and more detailed information about ADAP.

Provider Enrollment

On and after November 12, 2012, pharmacy providers are required to be enrolled (formerly referred to as certified) as ADAP providers to submit and adjust claims and receive reimbursement for services covered by ADAP. Pharmacy providers who currently provide ADAP services, including out-of-state pharmacy providers, will be required to re-enroll as ADAP providers using the ADAP Provider Enrollment Application on the Provider Enrollment Information page of the Portal. The ADAP Provider Enrollment Application will be available on the Portal beginning October 15, 2012. The ADAP Provider Enrollment Application is an enhanced paperless enrollment process. Paper enrollment applications will not be available. Providers may call the Electronic Data

Interchange (EDI) Helpdesk at (866) 416-4979 with technical questions about the online enrollment application.

Providers enrolling as ADAP providers are required to include their National Provider Identifier (NPI) on the enrollment application.

Current providers are encouraged to complete their ADAP enrollment prior to November 12, 2012, to allow time for their personal identification number letter, containing information necessary to establish a Portal account, to be generated and mailed and to enroll in electronic funds transfer (EFT).

Providers who do not enroll in ADAP prior to November 12, 2012, may begin enrolling as new ADAP providers on and after November 12, 2012.

Pharmacy providers currently enrolled in Medicaid are eligible to enroll as new ADAP providers, but are not required to do so if they do not provide ADAP services.

A letter was sent to current ADAP pharmacy providers in September 2012 with information about enrolling in ADAP using the new ADAP Provider Enrollment Application. Current ADAP providers who render services should re-enroll in ADAP following the procedures outlined in the letter. Providers are encouraged to enroll in ADAP at the request of members even if they did not receive the letter.

To verify whether or not a pharmacy provider is enrolled as an ADAP provider, members may call ADAP at (800) 991-5532 or (608) 267-6875.

Enrollment and Ongoing Responsibilities

Completing Enrollment Applications

Portal Submission

Providers are required to enroll in ADAP using the Portal. Though the provider enrollment application is available via the public Portal, the data are entered and transmitted through a secure connection to protect personal data. Applying for enrollment through the Portal offers the following benefits:

- Fewer returned applications. Providers who apply through the Portal are taken through a series of screens that are designed to guide them through the application process. This ensures that required information is captured and therefore reduces the instances of applications returned for missing or incomplete information.
- Instant submission. At the end of the online application process, applicants instantly submit their application to ForwardHealth and are given an application tracking number (ATN) to use in tracking the status of their application.
- Indicates documentation requirements. At the end of the online process, applicants are also given detailed instructions about what actions are needed to complete the application process.

Effective Date of ADAP Enrollment

The initial effective date of a provider's enrollment will be based on the date ADAP receives the complete and accurate enrollment application materials. An application is considered complete when all required information has been accurately submitted and all supplemental documents have been received by ADAP. The date the applicant submits his or her online provider enrollment application to ADAP is the earliest effective date possible and will be the effective date if both of the following are true:

- The applicant meets all applicable screening requirements, licensure, certification, authorization, or other credential requirements as a prerequisite for ADAP on the date of submission.
- Supplemental documents required by ADAP that were not uploaded as part of the enrollment process are received by ADAP within 30 calendar days of the date the enrollment application was submitted. To avoid a delay of the enrollment effective date, providers are encouraged to upload documents during the enrollment process.

If ADAP receives any applicable supplemental documents more than 30 calendar days after the provider submits the enrollment application, the provider's effective date will be the date all supplemental documents are received by Wisconsin Medicaid.

If providers believe their initial enrollment effective date is incorrect, they may request a review of the effective date. The request should include documentation indicating the enrollment criteria that were incorrectly considered. Requests for changes in enrollment effective dates should be sent to Provider Maintenance at the following address:

ForwardHealth
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

Notice of Enrollment Decision

Wisconsin ADAP will notify the provider of his or her enrollment status, Notification is usually within 10 business days, but no longer than 60 days, after receipt of the complete application for enrollment. ADAP will either approve the application and issue the enrollment or deny the application. If the application for enrollment is denied, ADAP will give the applicant reasons, in writing, for the denial.

Providers who meet the enrollment requirements will be sent a welcome letter and a copy of the signed provider agreement. Included with the letter is an attachment with important information such as effective dates and assigned provider type and specialty. This information will be used when conducting business with ADAP.

Tracking Enrollment Materials

Wisconsin ADAP allows providers to track the status of their enrollment application either through the Portal or by calling Provider Services. Providers who submitted their application through the Portal will receive an ATN upon submission.

Note: Providers are required to wait for the Notice of Enrollment Decision as official notification that enrollment has been approved. This notice will contain information the provider needs to conduct business with ADAP; therefore, an approved or enrolled status alone does not mean the provider may begin providing or billing for services.

Tracking Through the Portal

Providers are able to track the status of an enrollment application through the Portal by entering their ATN. Providers will receive current information on their application, such as whether it is being processed or has been returned for more information.

Tracking Through Provider Services

Providers may also check on the status of their submitted application by contacting Provider Services and giving their ATN.

Provider Enrollment Criteria

For ADAP enrollment for dispensing pharmaceuticals, the pharmacy provider is required to be licensed by the Wisconsin Department of Safety and Professional Services as a pharmacy, currently meeting all requirements in chapters 450 and 961, Wis. Stats., and chapters Phar 1 through 14 and CSB 1 and 2, Wis. Admin. Code.

Pharmacy Providers

Any pharmacy provider enrolled in ADAP who submits claims to ForwardHealth for pharmacy services is considered a pharmacy provider.

A pharmacist is an individual licensed as such under ch. 450, Wis. Stats. Wisconsin Medicaid does not enroll individual pharmacists.

Pharmacies that change ownership or locations are required to notify ForwardHealth of all changes, including a new license number. When pharmacies have multiple locations, each location with a unique license number is required to have its own Medicaid enrollment.

Medicare

Pharmacy providers are required to be Medicare certified if they provide a Medicare-covered service to a dual eligible. If the provider is not Medicare certified, the provider should refer the dual eligible to another Medicaid provider who is also Medicare certified.

Border State and Out-of-State Providers

Border state and out-of-state pharmacy providers are limited to those providers who are licensed in the United States. Border state and out-of-state pharmacy providers are required to be licensed in their own state of practice.

All border state and out-of-state pharmacy providers will be considered in-state providers for ADAP.

A border state or out-of-state pharmacy provider is required to be enrolled in ADAP if a member's commercial health insurance requires the member to obtain drugs from an out-of-state pharmacy provider.

Provider Addresses

ForwardHealth interChange has the capability of storing the following types of addresses and related information, such as contact information and telephone numbers:

- *Practice location address and related information.* This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and telephone number for member's use. With limited exceptions, the practice location and telephone number for member's use are published in a provider directory made available to the public.
- *Mailing address.* This address is where ForwardHealth will mail general information and correspondence. Providers should indicate concise address information to aid in proper mail delivery.
- *Financial addresses.* Two separate financial addresses are stored in interChange. The checks address is where ADAP will mail paper checks. The 1099 mailing address is where ADAP will mail IRS Form 1099.

Providers may submit additional address information or modify their current information through the Portal or by using the Provider Change of Address or Status form, F-01181 (10/12). The Provider Change of Address or Status form has been revised to accommodate ADAP. Providers may refer to Attachments 1 and 2 of this *Update* for a copy of the form.

Note: Providers are cautioned that any changes to their practice location on file with ForwardHealth may alter their ZIP+4 code information required on transactions. Providers may verify the ZIP+4 code for their address on the U.S. Postal Service Web site.

Provider addresses are stored separately for each program (i.e., Wisconsin Medicaid, Wisconsin ADAP, Wisconsin Chronic Disease Program [WCDP], and Wisconsin Well Woman Program [WWWP]) for which the provider is enrolled. Providers should consider this when supplying additional address information and keeping address information current. Providers who are enrolled in multiple programs and have an address change that applies to more than one program should provide this information for each program. Providers who submit these changes on paper need to submit one Provider Change of Address or Status form if changes are applicable for multiple programs. Providers may refer to the future ADAP area of the Online Handbook for complete information about provider addresses and keeping information current with ForwardHealth.

Member Information

Wisconsin ADAP provides eligible low-income Wisconsin residents living with Acquired Immune Deficiency Syndrome (AIDS) or HIV infection access to antiretroviral medications and certain other medications used in the treatment of AIDS or HIV infection. To be eligible for ADAP, an individual must meet the following requirements:

- Live in Wisconsin.
- Have an AIDS or HIV infection documented by a health care provider.
- Have gross household income that is at or below 300 percent of the Federal Poverty Level (FPL). Federal

Poverty Level guidelines are available on the FPL guidelines page of the Department of Health Services' (DHS) Web site at *www.dhs.wisconsin.gov/medicaid/fpl/fpl.htm.*

- Not be covered under the BadgerCare Plus Standard Plan or Wisconsin Medicaid.
- Have no health insurance or insurance that is insufficient to cover the cost of ADAP medications.

To apply for ADAP, an individual must complete and submit the AIDS/HIV Health Insurance Premium Subsidy Program and Drug Assistance Program Application/Recertification form, F-44614A (07/11), and the AIDS/HIV Drug Insurance Premium Subsidy Program and Drug Assistance Program Application/Recertification Part B — Physician Portion form, F-44614B (07/11). The applicant should complete Part A of the form and the applicant's health care provider is required to complete and submit Part B. The application form and instructions are available on the Wisconsin AIDS/HIV Drug Assistance Program page of the Portal at *www.dhs.wisconsin.gov/aids-hiv/Resources/Overviews/AIDS_HIV_drug_reim.htm*. The application form and instructions will be available on the Forms page of the Portal in the future.

Applications are also available from AIDS service organizations and community-based organizations that provide HIV case management services. Case managers at these agencies are available to assist individuals in applying for ADAP. A list of the agencies with contact information is included in the application instructions at the previously referred to link . Applicants with questions may contact ADAP by telephone at (800) 991-5532 or (608) 267-6875.

Enrollment Categories

The following table lists categories of enrollment categories for ADAP members.

Category	Detail
Members without insurance	Covered medications paid at 100 percent of ADAP allowable cost
Insurance with deductible and copayment or coinsurance without an out-of-pocket maximum	Covered medications paid at 100 percent of ADAP allowable cost until deductible is met, then ADAP pays the copayment or coinsurance
Insurance with deductible and copayment or coinsurance with an out-of-pocket maximum	Covered medications paid at 100 percent of ADAP allowable cost until deductible is met, then ADAP pays the copayment or coinsurance until the out-of-pocket maximum is met
Insurance with copayment or coinsurance without an out-of-pocket maximum	ADAP pays the copayment or coinsurance for covered medications
Insurance with copayment or coinsurance with an out-of-pocket maximum	ADAP pays the copayment or coinsurance for covered medications until the out-of-pocket maximum is met
BadgerCare Plus Core Plan	ADAP pays for brand name covered medications at 100 percent of ADAP allowable cost. (*Note:* The Core Plan pays for ADAP formulary generic medications.)
Wisconsin Medicaid with deductible (spenddown)	ADAP pays 100 percent of the ADAP allowable cost until the deductible (spenddown) is met, and then ADAP eligibility ends because Wisconsin Medicaid will pay for medications
Medicare Part D	Medicare Part D pays first. ADAP

Prescription Drug Plan	provides wrap-around coverage and pays for the portion not covered by Medicare Part D up to 100 percent of the ADAP allowable cost
Medicare Supplemental and Part D Prescription Drug Plan	Medicare Part D pays first then Medicare Supplemental. ADAP pays any remaining cost or copayment after other payers have paid
Dual eligible	If the member owes a copayment on a medication covered by ADAP, ADAP pays the copayment on behalf of the member

Enrollment Verification

Providers may verify member enrollment in the following ways:

- Submit a real-time claim to ADAP.
- Use the Portal. (*Note:* To verify enrollment using the Portal, providers enrolled in ADAP should log in to the Portal as an ADAP financial payer to access enrollment information for ADAP members.)
- Refer to the letter received from ADAP describing a member's ADAP coverage.
- Call ADAP at (800) 991-5532 or (608) 267-6875.

Enrollment verification for ADAP members is not available using WiCall.

For more information about enrollment verification, providers may refer to the ADAP area of the Online Handbook.

Identification Cards and Identification Numbers

Members enrolled in ADAP will not be issued identification cards. Providers may verify member enrollment using one of the options listed in the Member Enrollment Verification section of this *Update*.

Current ADAP members will receive a new member identification number with the transition to interChange. Pharmacy providers will receive a crosswalk list of members' previous ADAP member IDs to members' new ADAP member IDs. Providers may refer to the real-time claim response to determine a member's current identification number. For more information about member IDs, providers may refer to the ForwardHealth Payer Sheet: National Council for Prescription Drug Programs (NCPDP) Version D.0, P-00272 (11/12), on the Portal. The payer sheet is available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet page of the Trading Partners area of the Portal at *www.forwardhealth.wi.gov/WIPortal/Default.aspx?srcUrl=CompanionDocuments.htm&tabid=41*.

For drug claim submissions or reversals, providers may indicate either the member's previous identification number or the member's new identification number. Regardless of which identification number is used, providers will receive the new identification number in the real-time response. Providers may also obtain a member's identification number by calling ADAP or Provider Services.

Covered and Noncovered Services

Covered Services

Wisconsin ADAP has a closed drug formulary; ADAP covers antiretroviral drugs, prophylactic drugs, certain hepatitis C treatments, and vaccines for hepatitis A and B.

Providers may refer to the Wisconsin AIDS/HIV Drug Assistance Program (ADAP) Formulary in Attachment 3. The formulary may be revised monthly. Providers may refer to the Pharmacy page of the Providers area of the Portal at *www.forwardhealth.wi.gov/WIPortal/content/provider/medicaid/pharmacy/resources.htm.spage* for the most current formulary.

No covered ADAP services require prior authorization.

Manufacturer Rebate Agreements

The Wisconsin ADAP receives rebates from drug manufacturers through the following:

- Federal rebate agreements.
- The federal 340B program.
- Enhanced rebates negotiated on behalf of all state ADAP programs by the National ADAP Crisis Task Force.

Rebates received are directed back to the ADAP operating budget and are an important source of support for ADAP.

340B Program Rebate Agreements

The 340B program is designed to reduce drug costs for covered entities through an option to purchase drugs at lower U.S. Public Health Service rates or an option to receive rebates from manufacturers on drugs purchased at non-Public Health Service rates. Rebates are intended to bring the net price down to a rate similar to the Public Health Service rate.

Wisconsin ADAP does not directly purchase drugs and therefore participates in the 340B rebate option. Wisconsin ADAP reimburses pharmacy providers at Medicaid rates for ADAP-covered medications dispensed to ADAP members. On a quarterly basis, ADAP provides expenditure data to pharmaceutical companies. The companies then calculate the 340B rebate amount and issue rebates to ADAP.

National ADAP Crisis Task Force Rebate Agreements

Another source of rebates for ADAP is through the efforts of the National ADAP Crisis Task Force, a group convened by the National Alliance of State and Territorial AIDS Directors. The task force negotiates directly with the pharmaceutical companies on behalf of all state ADAP programs to obtain enhanced rebates that are applied on top of the standard 340B rebates.

Drug Addition Requests

Providers may submit the Drug Addition Review Request, F-00020 (10/12), to request an addition of an National Drug Code (NDC) to ADAP. Providers may fax the form to the Division of Health Care Access and Accountability (DHCAA) at (608) 266-1288. The Drug Addition Review Request has been revised to accommodate ADAP. Providers may refer to Attachment 4 for a copy of the form.

Noncovered Services

Drugs not listed on the ADAP formulary are considered noncovered services.

Billing Members for Noncovered Services

Members in ADAP may request noncovered services from providers. In those cases, providers may collect payment for the noncovered service from the member if the member accepts responsibility for payment and makes payment arrangements with the provider. Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for payment of the service.

Providers may bill members up to their usual and customary charge for noncovered services.

Providers are reminded to verify if members have other insurance before billing members for drugs that are not on the ADAP formulary.

Transitional Period in October and November 2012 for Claim Submissions

During the transition to interChange, the following timeline applies to claims for ADAP services:

- Through October 19, 2012 — Providers may continue to submit claims to ADAP using current claim submission procedures by fax at (608) 266-1288 or by mail to the following address:

  Division of Public Health
  ADAP Claims
  PO Box 2659
  Madison WI 53701-2659

Providers are encouraged to ensure their submission of claims is current by October 19, 2012.

- From October 20, 2012, through November 11, 2012 — Providers should hold claims and submit them after the transition to interChange is complete in November 2012. Wisconsin ADAP will not accept claims during this time. (*Note:* During this time, claims that are held will be reimbursed as long as the member is enrolled in ADAP on the DOS. Providers may verify member enrollment by calling ADAP. For members with prescriptions that will be refilled for DOS from October 20, 2012, through November 11, 2012, providers may obtain an early refill from ADAP following current procedures or refill the prescription and hold the claim for submission after the transition to interChange is complete in November 2012.)

Providers may call ADAP with questions about the transition to interChange.

Ongoing Procedures for Claim Submissions

Beginning November 12, 2012, providers may begin submitting claims for ADAP services using the Point-of-Sale (POS) system, Direct Data Entry (DDE), Provider Electronic Solutions (PES) software, or on paper by mail. Claims that are faxed will no longer be accepted by ADAP.

Providers are required to have a valid tax identification number (TIN) on file with ForwardHealth before claims or adjustment requests may be submitted to ADAP. ForwardHealth will generate payments to the provider and report income to the Internal Revenue Service (IRS) using this information. This information must be current taxpayer information on file with the IRS. Wisconsin ADAP will not reimburse providers without a valid TIN on file.

Point-of-Sale Claims

Wisconsin ADAP uses a voluntary pharmacy POS electronic claims management system. The POS system enables providers to submit electronic pharmacy claims for brand name and generic legend drugs in an online, real-time environment.

The pharmacy system verifies member enrollment and monitors pharmacy policy. Within seconds of submitting a real-time claim, these processes are completed and the provider receives an electronic response indicating payment or denial.

National Council for Prescription Drug Programs D.0 Telecommunications Standard

Wisconsin ADAP uses the NCPDP Telecommunication Standard Format Version D.0. Using this format, providers are able to complete the following:

- Initiate new claims and reverse and resubmit previously paid real-time claims.
- Submit individual claims or a batch of claims for the same member within one electronic transmission.

Providers may refer to the payer sheet on the Portal for more information about NCPDP standards.

Group ID

ForwardHealth uses the Group ID (301-C1) field for providers to indicate the appropriate payer for noncompound drug claims. On claims for ADAP members, "ADAP" should be indicated. Pharmacy providers are reminded to check this field on all POS claims to ensure the claim is being submitted to the correct ForwardHealth program for payment. On claims for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare members, "TXIX" should be indicated. On claims for WCDP members, "WCDP" should be indicated.

Direct Data Entry of Claims on the Portal

Claims for noncompound drugs may be submitted to ForwardHealth using DDE on the Portal. Direct Data Entry is an online application that allows providers to submit claims directly to ForwardHealth. Prior to submitting claims using DDE, providers with multiple Portal accounts must make sure the ADAP provider account is selected from the

Switch Organization option of the secure Provider area of the Portal.

When submitting claims via DDE, required fields are indicated with an asterisk next to the field. If a required field is left blank, the claim will not be submitted and a message will appear at the top of the claims screen prompting the provider to complete the specific required field(s). Portal help is available for each online application screen. In addition, search functions accompany certain fields so providers do not need to look up information in secondary resources.

On noncompound drug claims, providers may search for and select NDCs and place of service codes.

Using DDE, providers may submit claims for single-entity drugs. Any provider, including a provider of durable medical equipment or of disposable medical supplies, who submits noncompound drug claims may submit these claims via DDE. All claims are viewable via DDE regardless of submission method.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES software allows providers to submit NCPDP batch standard version 1.2 transactions, reverse claims, and review 835 Health Care Claim Payment/Advice (835) transactions. To obtain PES software, providers may download it from the Portal. Providers should select ADAP from the drop-down menu on claims submitted using PES software. For assistance installing and using PES software, providers may call the EDI Helpdesk.

Provider Electronic Solutions software will be upgraded on November 9, 2012. Therefore, providers may begin submitting claims for ADAP services using PES software beginning November 12, 2012.

The PES Manual has been revised to accommodate ADAP. The revised PES Manual is available on the PES Information page of the Trading Partner area of the Portal at *www.forwardhealth.wi.gov/WIPortal/Default.aspx?srcUrl=PESSoftwareInfo.htm&tabid=41*.

Paper Claims Submission

Providers may submit paper claims for drugs to ADAP. Paper claims may be submitted on the Noncompound Drug Claim, F-13072 (10/12). Paper claims are processed through the pharmacy system but do not furnish real-time claim responses. Providers who submit paper claims will receive claim status on a provider's remittance information. The Noncompound Drug Claim form accommodates NCPDP.

ForwardHealth has revised the Noncompound Drug Claim form to include ADAP. Providers may refer to Attachments 5 and 6 for a copy of the completion instructions and form.

Paper claim forms may be submitted for payment to the following address:

ForwardHealth
ADAP Claims and Adjustments
PO Box 8758
Madison WI 53708

Providers may no longer fax claims directly to ADAP.

Real-Time Claim Submission Requirements for Coordination of Benefits

Providers may refer to the payer sheet and the ADAP area of the Online Handbook for detailed information about real-time claim submission requirements for coordination of benefits for ADAP services.

Coordination of benefits examples are available in Attachment 7.

Days' Supply on Claims

Providers are required to dispense all legend drugs in the full quantity prescribed, not to exceed a 34-day supply. Pharmacy providers are required to indicate the actual quantity dispensed and the correct days' supply on claims for legend

drugs. Claims submitted with an incorrect days' supply are subject to audit and recoupment.

Claim Reversals

ForwardHealth is unable to electronically reverse claims at a provider's request. Providers can electronically reverse claims up to 365 days from the DOS or submit an Adjustment/Reconsideration Request form, F-13046 (07/12).

Providers may reverse or adjust previously paid ADAP claims that were converted to interChange for DOS on and after July 1, 2010. Claims may be reversed using the Portal on and after November 12, 2012, or providers may complete and submit an Adjustment/Reconsideration Request.

Timely Filing Appeals Requests

Requirements

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider is required to submit a Timely Filing Appeals Request form, F-13047 (07/12), with a paper claim or an Adjustment/Reconsideration Request form to override the submission deadline.

Dates of service that are beyond the submission deadline should be submitted separately from DOS that are within the deadline. The timely filing deadline for ADAP claims is 365 days. Claims or adjustment requests received that contain both current and late DOS are processed through normal channels without review by Timely Filing, and late DOS will be denied.

Providers may refer to the ADAP area of the Online Handbook for detailed information about timely filing appeals requests.

Submission Deadline

To receive consideration for an exception to the submission deadline, providers are required to submit the following:

- A properly completed Timely Filing Appeals Request form for each claim and each adjustment to allow for electronic documentation of individual claims and adjustments submitted to ForwardHealth.
- A legible claim or adjustment request.
- All required documentation as specified for the exception to the submission deadline.

To receive consideration, a Timely Filing Appeals Request must be received before the deadline specified for the exception to the submission deadline.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, place of service code, etc., as effective for the DOS; however, providers should use the current claim form and instructions or adjustment request form and instructions. Reimbursement for Timely Filing Appeals Requests is contingent upon the claim or adjustment request meeting program requirements for the DOS.

Providers may refer to Attachment 9 for information about timely filing exemptions, documentation requirements, and submission addresses.

Resubmission

Decisions on Timely Filing Appeals Requests cannot be appealed. Providers may resubmit the claim to Timely Filing if both of the following occur:

- The provider submits additional documentation as requested.
- ForwardHealth receives the documentation before the specified deadline for the exception to the submission deadline.

Claim Responses

Providers may refer to the ADAP area of the Online Handbook for detailed information about claim responses, including information about RAs.

Remittance Advice Financial Cycles

Each financial payer (Medicaid, ADAP, WCDP, and WWWP) has separate financial cycles that occur on different days of the week. Remittance Advices are generated and posted to secure provider Portal accounts after each financial cycle is completed. Therefore, RAs may be generated and posted to secure provider Portal accounts from different payers on different days of the week.

ForwardHealth will accept electronic claims at any time, including holidays. For claims for ADAP services to be included in the financial cycle, claims must have completed the claims processing cycle by 6:00 p.m. on Mondays, regardless of the submission method (paper or electronic).

Certain financial transactions may run on a daily basis, including non-claim-related payouts and stop payment reissues. Providers may have access to the RAs generated and posted to secure provider Portal accounts for these financial transactions at any time during the week.

Remittance Advice Generated by Payer and by Provider Enrollment

Remittance Advices are generated and posted to secure provider Portal accounts from one or more of the following ForwardHealth financial payers:

- Wisconsin AIDS/HIV Drug Assistance Program.
- Wisconsin Chronic Disease Program.
- Wisconsin Medicaid (Wisconsin Medicaid is the financial payer for the Medicaid, BadgerCare Plus, and SeniorCare programs).
- Wisconsin Well Woman Program.

A separate Portal account is required for each financial payer.

Note: Each of the four payers generate separate RAs for the claims, adjustment requests, or other financial transactions submitted to the payer. A provider who submits claims, adjustment requests, or other financial transactions to more than one of these payers may receive several RAs.

The RA is generated per provider enrollment. Providers who have a single NPI that is used for multiple enrollments should be aware that an RA will be generated for each enrollment, but the same NPI will be reported on each of the RAs.

For instance, a hospital with a clinic, a lab, and a pharmacy that are all enrolled in ForwardHealth has obtained a single NPI. The clinic, the lab, and the pharmacy submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Coordination of Benefits

Providers are required to follow ADAP policies even if a member's commercial health insurance has a different policy.

Provider-Based Billing

Purpose of Provider-Based Billing

The purpose of provider-based billing is to reduce costs by ensuring that providers receive maximum reimbursement from other health insurance sources that are primary to ADAP. For example, a provider-based billing claim is created when ADAP pays a claim and later discovers that other coverage exists or was made retroactive. Since ADAP benefits are secondary to those provided by most other health insurance sources, providers are required to seek reimbursement from the primary payer.

Providers may refer to the Coordination of Benefits section of the ADAP area of the Online Handbook for detailed information about provider-based billing.

Responding to ADAP Within 120 Days

Within 120 days of the date on the Provider-Based Billing Summary, the Provider-Based Billing Unit must receive documentation verifying that one of the following occurred:

- The provider discovers through enrollment verification methods that ADAP has removed or enddated the other health insurance coverage from the member's file.

- The provider verifies that the member's other coverage information reported by ADAP is invalid.
- The other health insurance source reimbursed or partially reimbursed the provider-based billing claim.
- The other health insurance source denied the provider-based billing claim.
- The other health insurance source failed to respond to an initial and follow-up provider-based billing claim.

When responding to ADAP within 120 days, providers are required to submit the required documentation to the appropriate address as indicated in the table in Attachment 10. If the provider's response to ADAP does not include all of the required documentation, the information will be returned to the provider. The provider is required to send the complete information within the original 120-day limit.

Providers may refer to Attachment 10 for documentation requirements and submission addresses for responding to ADAP within 120 days.

Responding to ADAP After 120 Days

If a response is not received within 120 days, the amount originally paid by ADAP will be withheld from future payments. This is not a final action. To receive payment after the original payment has been withheld, providers are required to submit the required documentation to the appropriate address as indicated in Attachment 11.

Providers may refer to Attachment 11 for scenarios, documentation requirements, and submission addresses for responding to ADAP for DOS that are within and beyond claims submission deadlines.

Enrollment Responsibilities

Loss of Enrollment — Financial Liability

Members are financially responsible for any services received after their enrollment has been terminated. The provider may collect payment from the member if the member accepts responsibility for payment of a noncovered service and certain conditions are met.

To avoid misunderstandings, it is recommended that providers remind members that they are financially responsible for any continued care after enrollment ends.

Member Cooperation

Members are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a member has other health insurance, it is the member's obligation to give full and accurate information to providers regarding the insurance.

Applicant and Member Enrollment Rights

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to ADAP enrollment. An applicant, a member, or authorized person acting on behalf of the applicant, member, or former member may file the appeal with the Division of Hearings and Appeals (DHA).

Pursuant to ch. HA 3.03, Wis. Admin. Code, an applicant, member, or former member may appeal any adverse action or decision by an agency or department that affects his or her benefits. Examples of decisions that may be appealed include, but are not limited to, the following:

- Individual was denied the right to apply.
- Application for ADAP was denied.
- Application for ADAP was not acted upon promptly.
- Enrollment was unfairly discontinued, terminated, suspended, or reduced.

In the case when member enrollment is cancelled or terminated, the date the member, or authorized person acting on behalf of the member, files an appeal with the DHA determines what continuing coverage, if any, the member will receive until the hearing decision is made. The following scenarios describe the coverage allowed for a member who files an appeal:

- If a member files an appeal before his or her enrollment ends, coverage will continue pending the hearing decision.

- If a member files an appeal within 45 days after his or her enrollment ends, a hearing is allowed but coverage is not reinstated.

If the member files an appeal more than 45 days after his or her enrollment ends, a hearing is not allowed. Members may file an appeal by submitting a Request for Fair Hearing form, DHA-28 (08/09).

Claims for Appeal Reversals

If a claim is denied due to termination of member enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
ADAP Claims and Adjustments
PO Box 8758
Madison WI 53708

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to ADAP.

Claim submission deadlines still apply even to those claims with hearing decisions.

Freedom of Choice

Members may receive covered services from any willing ADAP-enrolled provider, but are encouraged to use a single provider and to notify ADAP if they would like to change providers.

Prompt Decisions on Enrollment

Individuals applying for ADAP have the right to prompt decisions on their applications. Member enrollment decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

Special Member Enrollment Circumstances

ADAP Members from Other States

Wisconsin ADAP does not pay for services provided to individuals who live outside Wisconsin who are enrolled in other state ADAP programs. Providers are advised to contact other state ADAP programs to determine whether the service sought is a covered service under that state's ADAP program.

Early Refills for Members Traveling Out of State

When a member travels out of state, an early refill of a member's medication may be allowed in the following circumstances:

- If the member has an appropriate medical need (e.g., the member's medications were lost or stolen, the member has requested a vacation supply).
- A member has been taking too much of a medication because he or she misunderstood the directions for administration from the prescriber.
- A prescriber changed the directions for administration of the drug and did not inform the pharmacy provider.

Pharmacy providers should call prescribers to verify the directions for use or to determine whether or not the directions for use changed.

Persons Detained by Legal Process

Members detained by legal process who are currently enrolled in ADAP and reside in a county jail may continue to be covered by ADAP.

Members detained by legal process who currently reside in a county jail or in a state correctional facility and are not enrolled in ADAP are not eligible to enroll.

Retroactive Member Enrollment

Retroactive member enrollment occurs when an individual has applied for ADAP and enrollment is granted with an effective date prior to the date the enrollment determination was made. A member's enrollment may be backdated to

allow retroactive coverage for pharmacy bills incurred prior to the date of application.

The retroactive member enrollment period may be backdated up to 30 days prior to the month of application if all enrollment requirements were met during the period. Enrollment may be backdated more than three months if there were delays in determining enrollment or if court orders, fair hearings, or appeals were involved.

Reimbursing Members in Cases of Retroactive Enrollment

When a member receives retroactive enrollment, he or she has the right to request the return of payments made to an ADAP-enrolled provider for a covered service during the period of retroactive enrollment. An ADAP-enrolled provider is required to submit claims to ADAP for covered services provided to a member during periods of retroactive enrollment. Wisconsin ADAP cannot directly refund the member.

If a provider receives reimbursement from ADAP for services provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (e.g., local General Relief agency) the full amount that the member paid for the service.

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full; therefore, total payment for the service (i.e., any amount paid by ADAP or other health insurance sources) may not exceed the allowed amount. As a result, providers may not collect payment from a member, or authorized person acting on behalf of the member, for the difference between his or her usual and customary charge and the allowed amount for a service (i.e., balance billing).

Other health insurance payments may exceed the allowed amount if no additional payment is received from the member or ADAP.

Dispensing Fees

With the implementation of interChange, ADAP will use the same dispensing fee as Wisconsin Medicaid.

Effective for DOS on and after November 12, 2012, the dispensing fee for covered brand name drugs is $3.44 per prescription. For covered generic drugs, the dispensing fee is $3.94.

Services covered under the dispensing fee include record keeping, patient profile preparation, and counseling. The dispensing fee is usually paid once per member, per service, per month, per provider, depending on the physician's prescription.

Drug Reimbursement

Wisconsin ADAP uses Medicaid pricing methodology. Medicaid pricing methodology includes the following:

- Expanded Maximum Allowed Cost (EMAC).
- State MAC (SMAC).
- Wholesale Acquisition Cost (WAC).

The DHS determines maximum reimbursement rates for all covered pharmaceutical drug items. Maximum reimbursement rates may be adjusted to reflect market rates, reimbursement limits, or limits on the availability of federal funding as specified in federal law (42 CFR 447.512).

Some covered legend drugs are reimbursed at either the drug's WAC rate plus a dispensing fee or the provider's usual and customary charge, whichever is less. Other legend drugs are reimbursed at either the drug's price on the State Maximum Allowed Cost List plus a dispensing fee or the provider's usual and customary charge, whichever is less. If a federal, legend drug does not have a WAC rate, an expanded MAC rate will be assigned.

Updates to pricing methods on claims submitted with an NDC are automatically completed monthly by First DataBank. The WAC rates are provided to ForwardHealth by First DataBank. First DataBank is a contracted drug clearinghouse.

For the most current EMAC and SMAC rates, providers may refer to the Expanded Maximum Allowed Cost List and the State Maximum Allowed Cost List on the Pharmacy page of the Portal.

Multiple Rates or No Rates on File

If an NDC has multiple rates (e.g., WAC, SMAC, and EMAC) on file and is a non-innovator, the NDC will be reimbursed at the lesser of the rates on file. A generic copayment and generic dispensing fee will be applied in this situation.

If an NDC does not have a WAC, SMAC, or EMAC rate on file, the claim will be denied.

State Maximum Allowed Cost

Under Wisconsin's State Medicaid Plan approved by the U.S. Department of Health and Human Services, Wisconsin Medicaid may assign SMACs to establish an upper limit for payment of brand or generic versions of the same drug (federal legend or over-the-counter [OTC] drugs), regardless of manufacturer. State MAC rates are set by using best estimates of prices currently in the marketplace in comparison to WAC as stated in the approved Wisconsin State Plan. Because Medicaid rates apply to ADAP and WCDP, ADAP and WCDP may assign SMACs to establish an upper limit for payment of brand or generic versions of the same drug (federal legend or OTC drugs), regardless of the manufacturer.

Providers will receive informational Explanation of Benefits code on pharmacy noncompound claims that are reimbursed at the SMAC rate.

State Maximum Allowed Cost Drug Pricing Review

To request a review of SMAC pricing, pharmacy providers are required to submit the State Maximum Allowed Cost Drug Pricing Review Request, F-00030 (07/12), along with supporting documentation. Requests to review MAC rates should be submitted to Wisconsin Medicaid, not ADAP, since ADAP does not determine MAC rates.

Pharmacy providers are required to submit the following supporting documentation along with the State Maximum Allowed Cost Drug Pricing Review Request form signed by a pharmacist certifying that the price listed is the actual new cost after rebates or discounts from a wholesaler. Supporting documentation must include:

- Date of purchase.
- Invoiced provider.
- Wholesaler name.
- Product NDC. If the NDC is not indicated on the invoice, the provider is required to handwrite the NDC on the invoice.
- Invoice price.

The State Maximum Allowed Cost Drug Pricing Review Request form and the supporting documentation must be submitted to the Drug Authorization and Policy Override (DAPO) Center via fax at (608) 250-0246 or by mail to the following address:

ForwardHealth
Drug Authorization and Policy Override Center
313 Blettner Blvd
Madison WI 53784

Any action taken by ForwardHealth will be reflected in the SMAC data table.

Wholesale Acquisition Cost

The DHS has established different estimated acquisition costs for brand name drugs and generic drugs using WAC reimbursement.

Brand Wholesale Acquisition Cost

The brand WAC reimbursement rate for brand name drugs for BadgerCare Plus, Medicaid, SeniorCare, ADAP, and WCDP prescriptions is WAC plus two percent.

National Drug Codes use the brand WAC reimbursement rate and brand dispensing fee for either of the situations below:

- Situation 1:
  - ✓ The drug does not have an SMAC rate on file.
  - ✓ The NDC is defined by First DataBank as a brand name drug.
- Situation 2:
  - ✓ The drug has an SMAC rate on file.
  - ✓ The NDC is defined by First DataBank as a brand name drug.
  - ✓ The NDC is defined as an innovator and is billed with a Dispense as Written (DAW) code of 1 or 8.

Generic Wholesale Acquisition Cost

The generic WAC reimbursement rate for generic drugs for BadgerCare Plus, Medicaid, SeniorCare, ADAP, and WCDP prescriptions will be WAC minus 3.8 percent.

National Drug Codes use the generic WAC reimbursement rate and generic dispensing fee if the following apply:

- The drug does not have an SMAC rate on file.
- The NDC is defined by First DataBank as a generic drug or non-drug item.
- The NDC is not defined as an innovator.

Reimbursement for Brand Name and Generic Drugs

Wisconsin ADAP reimburses providers for innovator drugs (i.e., the patented brand name product of the generic drug on the State Maximum Allowed Cost List) at an amount greater than the Medicaid maximum allowable cost only if the prescriber indicates "Brand Medically Necessary" on the prescription. If a generic equivalent of a brand name drug is available, a claim must be submitted for the generic drug unless the prescriber indicates "Brand Medically Necessary" on the prescription and the appropriate DAW code is indicated on the claim. If only a brand name drug is available, "Brand Medically Necessary" does not need to be indicated on the prescription and a DAW code does not need to be indicated on the claim.

Providers may refer to the ADAP formulary on the Pharmacy page of the Portal for the most current list of drugs covered by ADAP.

Electronic Funds Transfer

Electronic funds transfer allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. Electronic funds transfer is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Enrolling in Electronic Funds Transfer

A Portal account is required to enroll in EFT as all enrollments must be completed via a secure provider Portal account or a secure managed care organization Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may Request Portal Access online. Providers may also call the Portal Helpdesk for assistance in requesting a Portal account.

Providers are required to have a valid TIN on file with ForwardHealth before enrolling in EFT. ForwardHealth will generate payments to the provider and report income to the IRS using this information. This information must be current taxpayer information on file with the IRS. Wisconsin ADAP will not reimburse providers without a valid TIN on file.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations cannot revert back to receiving paper checks once enrolled in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their RA as they do currently.

Refer to the Electronic Funds Transfer User Guide on the Portal User Guides page of the Portal at *www.forwardhealth.wi.gov/WIPortal/content/Provider/userguides/use*

rguides.htm.spage for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into "Active" status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the process of recouping funds. Overpayments and recoupment of funds will be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances, an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (e.g., a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

If payment is not deposited into the designated EFT account according to the ForwardHealth payment cycle, providers should first check with their financial institution to confirm the payment was received. If the payment was not received, providers should then call Provider Services to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

ADAP as Payer of Last Resort

Wisconsin ADAP is payer of last resort of any ADAP-covered services. When coverage exists, a provider is required to submit a claim to commercial health insurance sources, Medicare, Health Insurance Risk Sharing Program, Wisconsin Medicaid, BadgerCare Plus, and SeniorCare before submitting it to ADAP.

A claim will be denied if it is not submitted to other payers or if other insurance explanation code or Medicare disclaimer code is used inappropriately. For example, if a member does not have Medicare, a Medicare disclaimer code should not be indicated on a claim.

Wisconsin ADAP will not reimburse a provider for performing a service if the provider receives payment for the service from workers' compensation or from civil liabilities (e.g., for injuries from an automobile accident).

Resources

Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

Providers may refer to Attachment 8 for the Provider Services and Resources Reference Guide.

Drug Search Tool

Wisconsin ADAP is not included in the Drug Search Tool.

Provider Services

The Provider Services Call Center provides service-specific assistance to Medicaid, BadgerCare Plus, ADAP, WCDP, and WWWP providers. Providers may call Provider Services at (800) 947-9627 for questions about enrollment policy and billing instructions. For more information about Provider Services, providers may refer to the future ADAP area of the Online Handbook.

For questions about ADAP policies and member enrollment, providers may call ADAP at (800) 991-5532 or (608) 267-6875.

Members should call ADAP with questions. Members should not be referred to Provider Services.

Provider Relations Representatives

The Provider Relations representatives, also known as field representatives, conduct training sessions on various ForwardHealth topics for both large and small groups of providers and billers. In addition to provider education, field representatives are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

For more information about field representatives and a map of field representatives by regions of the state, providers may refer to the Provider Relations Representatives topic (topic #473) in the Contact Information chapter of the Resources section in the Online Handbook.

Field Representative Specialization

The field representatives are assigned to specific regions of the state. In addition, the field representatives are specialized in a group of provider types. This specialization allows the field representatives to most efficiently and effectively address provider inquiries. To better direct inquiries, providers should contact the field representative in their region who specializes in their provider type.

Written Inquiries

Providers may submit written inquiries to ADAP to the following address:

ForwardHealth
ADAP Written Correspondence
PO Box 8758
Madison WI 53708

Providers are encouraged to use the other resources before mailing a written request to ADAP.

ForwardHealth Portal

ADAP providers may use the Portal for the following:

- Submit and adjust claims.
- View previously submitted claims.
- Verify member enrollment.
- View RAs.
- Designate which trading partner is eligible to receive the provider's 835 transaction.
- Update and maintain provider file information. Providers may indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT.

Providers may refer to the ADAP area of the Online Handbook or to the Portal User Guides for more information about the Portal.

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers are required to designate a trading partner to receive their 835 transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers are required to first complete the following steps:

- Access the Portal and log in to their secure account by clicking the Provider link/button.
- Click the **Designate 835 Receiver** link on the right-hand side of the secure home page.
- Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
- Click **Save**.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI Helpdesk or submit a paper form.

Online Handbook

The Online Handbook allows providers access to all policy and billing information for ForwardHealth programs in one

centralized place. A secure Portal account is not required to use the Online Handbook as it is available to all Portal visitors.

Revisions to policy information are generally incorporated immediately after policy changes have been issued in *Updates*. The Online Handbook also links to the ForwardHealth Publications page.

A Portable Document Format (PDF) archive of the ADAP area of the Online Handbook will not be available for providers.

ForwardHealth Portal Helpdesk

Providers and trading partners may call the Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Electronic Data Interchange

NCPDP Version D.0 Payer Sheet

ADAP providers should refer to the ForwardHealth Payer Sheet: NCPDP Version D.0, available for download on the Portal, for more information about electronic transactions. The payer sheet has been revised to include information applicable to ADAP providers.

The payer sheet is available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet page of Trading Partner area of the Portal at *www.forwardhealth.wi.gov/WIPortal/Default.aspx?srcUrl=CompanionDocuments.htm&tabid=41*.

Revisions to Payer Sheet

The payer sheet may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised payer sheet on the Portal.
- Post a message on the banner page of the RA.
- Send an e-mail to trading partners.

Trading partners are encouraged to periodically check for the revised payer sheet on the Portal. If trading partners do not follow the revisions identified on the payer sheet, transactions may not process successfully (e.g., claims may deny or process incorrectly).

Revisions to the payer sheet are listed in Appendix A of the payer sheet. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Data Exchange Methods

The following data exchange methods are supported by the EDI Helpdesk:

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software.
- Secure Web, using an Internet Service Provider and a personal computer with a modem, browser, and encryption software.
- Real-time, by which pharmacy providers exchange the NCPDP D.0 transactions via an approved clearinghouse.

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Wisconsin Medicaid, SeniorCare, Wisconsin ADAP, WCDP, and WWWP.

Electronic Data Interchange Helpdesk

The EDI Helpdesk assists anyone interested in becoming a trading partner with getting started and provides ongoing support pertaining to electronic transactions. Providers, billing services, and clearinghouses are encouraged to contact the EDI Helpdesk at (866) 416-4979 for test packets and/or technical questions.

Providers with policy questions should call Provider Services.

Electronic Transactions

Trading partners may submit claims and adjustment requests, inquire about member enrollment, claim status, and ForwardHealth payment advice by exchanging electronic transactions.

Trading partners may exchange the following electronic transactions:

- The 835, which is the electronic transaction for receiving remittance information.
- NCPDP D.0 Telecommunication Standard for Retail Pharmacy Claims, which is the real-time POS electronic transaction for submitting pharmacy claims.

Trading Partner Profile

A Trading Partner Profile must be completed, a Trading Partner Agreement must be signed, and a user account must be created before claims may be submitted to ForwardHealth.

In addition, billing providers who do not use a third party to exchange electronic transactions and billing services are required to complete a Trading Partner Profile.

To determine whether a Trading Partner Profile is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES software, are required to complete the Trading Partner Profile.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to complete a Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI Helpdesk.

Trading Partners

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.

Trading partners may request a trading partner ID following these steps:

1. Go to the Portal.
2. Click the **Trading Partners** link/button.
3. Click **Trading Partner Profile**.
4. Click submit **online** for the appropriate type of trading partner.
5. Click **next**.
6. Complete the Trading Partner Profile wizard.
7. Click **Submit** when complete.

Providers may download a Trading Partner Testing Packet from the Trading Partners area of the Portal at *www.forwardhealth.wi.gov/WIPortal/Default.aspx?srcUrl=Trading%20Partner%20Profile.htm&tabid=41*. The testing packet includes instructions on how to become a trading partner and submit transactions.

Forms

Providers may refer to the Forms page of the Providers area of the Portal at *www.forwardhealth.wi.gov/WIPortal/content/provider/forms/index.htm.spage#* for the most current forms.

ForwardHealth Updates

Wisconsin ADAP will begin issuing *Updates*, which are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, claims submission requirements, and training announcements.

The *ForwardHealth Update Summary* is posted to the Portal on a monthly basis and contains an overview of *Updates* published that month. Providers with a Portal account and registered to receive e-mail notifications are notified when the *Update Summary* is available on the Portal.

Updates included in the *Update Summary* are posted in their entirety on the Provider area of the Portal. Providers may

access *Updates* from direct links in the electronic *Update Summary* as well as navigate to other ForwardHealth information available on the Portal.

Registering for E-Mail Subscription

Providers and other interested parties may sign up on the Portal to receive e-mail notifications of new provider publications. In the future, users will be able to select the ADAP program for publication notifications they would like to receive. Any number of staff and other interested parties from an organization may sign up for an e-mail subscription.

Refer to the ForwardHealth Provider Portal E-Mail Subscriptions User Guide available on the References and Tools page of the Providers area of the Portal.

Updates included in the *Update Summary* are posted in their entirety on the Provider area of the Portal. Providers may access *Updates* from direct links in the electronic *Update Summary* as well as navigate to other ForwardHealth information available on the Portal.

Providers without Internet access may call Provider Services to request a paper copy of an *Update*. To expedite the call, correspondents will ask providers for the *Update* number. Providers should allow seven to 10 business days for delivery.

Full Text Publications Available

Providers may request full-text versions of *Update*s to be mailed to them by calling Provider Services. For more information about ADAP, providers may refer to the Wisconsin AIDS/HIV Program Web site at *www.dhs.wisconsin.gov/aids-hiv/*.

This *Update* was issued on 10/29/2012 and information contained in this *Update* was promoted to the Wisconsin AIDS Drug Assistance Program Online Handbook on 10/04/2013.

ATTACHMENT 1
Provider Change of Address or Status Completion Instructions

(A copy of the "Provider Change of Address or Status Completion Instructions" is located on the following pages.)

(This page was intentionally left blank.)

FORWARDHEALTH
PROVIDER CHANGE OF ADDRESS OR STATUS COMPLETION INSTRUCTIONS

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

Personally identifiable information about providers is used for purposes directly related to program administration such as determining the certification of providers or processing provider claims for reimbursement. Non-submission of changes in address or status may result in incorrect reimbursement, misdirected payment, claim denial, or suspension of payments.

Provision of the information requested on this form is mandatory; however, the use of this version of the form is voluntary. Providers may develop their own version of this form as long as it includes all the information on this form.

INSTRUCTIONS

If a request is made to change an individual provider's file, ForwardHealth requires a signature from the individual provider or an authorized representative on the Provider Change of Address or Status form, F-01181.

Complete all areas of the form affected by change. A change in ownership, group affiliation, federal tax identification number (TIN) (Internal Revenue Service [IRS] number), etc., must be reported to ForwardHealth before the change. A change in address must be reported immediately after moving.

Identifying Information is required to be filled out in addition to the sections where the change to the provider file is indicated. It is imperative that the information in Identifying Information is provided in order for ForwardHealth to update the correct provider file.

IDENTIFYING INFORMATION

The information in this section is used solely to identify the provider submitting the form and is not intended to include the provider's updated information. Only use information currently on file with ForwardHealth that pertains to the provider who performs ForwardHealth services and the location where the provider office is physically located and where the records are normally kept.

Element 1 — Name — Provider
This is a required field. Enter the individual provider's first name, middle initial, and last name, or the name of the clinic or facility.

Element 2 — Provider ID
This is a required field. Enter the provider's National Provider Identifier (NPI). Non-healthcare providers are required to enter the provider number assigned by ForwardHealth at the time of certification.

Element 3 — Taxonomy Code
This is a required field for health care providers and not applicable to specialized medical vehicle, personal care-only agencies, and blood bank providers. Enter the provider's taxonomy code assigned by ForwardHealth to be used to identify the provider file to be updated.

Element 4 — ZIP Code
This is a required field. Enter the five-digit ZIP code for the practice location on file with ForwardHealth.

Element 5 — ZIP+4 Extension
This is a required field. Enter the four-digit ZIP code extension for the practice location on file with ForwardHealth.

Element 6 — Updates on this form are applicable to the following programs.
This is a required field. Check all programs to which the provider file changes apply. Only choose programs for which the provider is certified.

Note: Sections I-IX should be used to report or change information currently on file with ForwardHealth.

SECTION I — PRACTICE LOCATION INFORMATION

Practice location is the street address where a provider office is physically located and where the records are normally kept.

IMPORTANT
Street Address Lines 1 and 2 may not contain any P.O. Box or drop box information.

Element 7 — Name — Provider
Enter the name of the Provider.

Element 8 — National Provider Identifier (NPI)
Enter the provider's NPI. This element is for health care providers who are reporting a change to their NPI currently on file with ForwardHealth.

Elements 9-14 — Practice Location Address
Enter the provider's complete practice location address (street, city, state, ZIP code, and ZIP+4 extension). This address is where the provider's office is physically located and where records are normally kept. It is not acceptable to indicate a P.O. Box or drop box for the practice location address.

Element 15 — County
Enter the county of the provider's practice location.

Element 16 — Telephone Number — For Member Use
Enter the telephone number that members should use to contact the provider. This telephone number will be listed in a provider directory that is available to the public.

Elements 17 and 18 — Name and Telephone Number — Contact Person
Enter the name and telephone number for the contact person. The contact person's telephone number is required when a contact person's name is entered. The contact person's information is used for ForwardHealth administrative purposes only.

SECTION II — PROVIDER FINANCIAL INFORMATION

ForwardHealth will generate payments to the provider and report income to the IRS using this information. This information must be the current taxpayer information on file with the IRS.

Taxpayer Information

Element 19 — Taxpayer Identification Number (TIN)
This is a required field. Enter the TIN that should be used to report income to the IRS.

Element 20 — Name — Taxpayer
This is a required field. Enter the taxpayer's name for the TIN indicated in Element 18. The name entered must be the same name that is on file with the IRS.

Element 21 — TIN Type
This is a required field. Indicate whether the TIN indicated in Element 18 is an Employer Identification Number (EIN) or a Social Security number (SSN).

Element 22 — TIN Effective Date
Enter the effective date of the TIN.

Element 23 — TIN End Date
Enter the end date of the TIN.

Checks and Remittance Advice Address

Element 24 — Name — Pay To
Enter the pay-to name.

Elements 25-30 — Address
These are required fields. Enter the complete address to which checks and Remittance Advices should be mailed.

Elements 31-32 — Name and Telephone Number — Contact Person
Enter the financial contact person's name and telephone number.

SECTION III — IRS FORM 1099 MAILING ADDRESS

ForwardHealth will mail the IRS Form 1099 to this address.

IMPORTANT
Only one 1099 will be sent per TIN. If the provider completing this form is not responsible for receiving the 1099, the provider should not complete this section.

Elements 33-38 — IRS Form 1099 Mailing Address
Enter the complete address to which the IRS Form 1099 should be sent. (Enter either a P.O. Box or street address [include a suite number, if applicable], city, state, and ZIP+4 code).

SECTION IV — MAILING INFORMATION
Indicate the address where ForwardHealth should send general information and correspondence.

Element 39 — Name – Mail To
Enter the first name, middle initial, last name, or the name of the office, clinic, facility, or place of business for the mailing address.

Element 40 — Name — Attention Line
Enter attention line information ForwardHealth should use for mailing general information and correspondence.

Elements 41-46 — Mailing Address
Enter the provider's complete mailing address. (Enter either a P.O. Box or street address [include a suite number, if applicable], city, state, ZIP code, and ZIP+4 extension.)

SECTION V — PRIOR AUTHORIZATION INFORMATION
Indicate the address where ForwardHealth should send prior authorization (PA) information. This section is not applicable for Wisconsin Well Woman Program providers.

Element 47 — Name — Provider
Enter the first name, middle initial, last name, and title or the name of the office, clinic, facility, or place of business for the PA address.

Element 48 — Name — Attention Line
Enter the attention line information that ForwardHealth should use for mailing PA information.

Elements 49-54 — Address
Enter the provider's complete PA address. (Enter either a P.O. Box or street address [include a suite number, if applicable], city, state, and ZIP+4 code).

Elements 55 — Fax Number
Enter the fax number.

Elements 56 — Telephone Number — Contact Person
Enter the telephone number for the contact person.

SECTION VI — SUPERVISING PROVIDER INFORMATION
For non-billing providers only. Indicate the following information for the non-billing provider's supervisor.

Element 57 — Name — Supervisor
Enter the supervisor's first name, middle initial, and last name.

Element 58 — Telephone Number — Supervisor
Enter the supervisor's telephone number, including the area code.

Elements 59-64 — Address
Enter the supervisor's complete physical address. (Enter a street address [include a suite number, if applicable], city, state, ZIP code, and ZIP+4 extension.)

Elements 65 — Effective Date of Supervision
Enter the date the supervisor began supervising the non-billing provider.

SECTION VII — GENERAL INFORMATION
Enter other miscellaneous information regarding the provider.

Elements 66 — Language(s)
Indicate the language(s) spoken by the organization's staff who are available to interpret for members. This information will be used in a provider directory that will be made available to the public. Check all that apply.

Element 67a-d — Drug Enforcement Agency (DEA) Information
Enter the DEA number(s) for the provider. Additional space is provided to allow for multiple DEA numbers.

Elements 68-69 — Medicare Enrollment
Indicate the provider's Medicare enrollment(s) and the effective date(s).

SECTION VIII — TAXONOMY
Indicate the provider's taxonomy codes intended to be used when conducting business with ForwardHealth.

IMPORTANT
A primary taxonomy code must be on file with ForwardHealth at all times. If a primary taxonomy code is being removed, a new one must be indicated.

Element 70 — Primary Taxonomy Code
Indicate the provider's primary taxonomy code. When changing a primary taxonomy code, indicate whether to keep or remove the previous primary taxonomy code on file with ForwardHealth.

Elements 71-75a-b — Additional Taxonomy Codes
Indicate the provider's additional taxonomy codes, and whether to add or remove the code from the provider's file with ForwardHealth.

SECTION IX —SUBPART NATIONAL PROVIDER IDENTIFIER INFORMATION
For hospital providers only. Indicate the hospital provider's subpart NPIs intended to be used when conducting business with ForwardHealth.

IMPORTANT
Hospital providers may have identified subparts for their organization and obtained an NPI for those subparts. ForwardHealth programs do not separately certify some hospital subparts such as psychiatric and rehabilitation units; however, the NPI and taxonomy codes of those subparts will be linked to the certified inpatient or outpatient hospital provider file. This enables providers to conduct business with ForwardHealth using NPIs for subparts that ForwardHealth programs do not separately certify.

Elements 76-80a-c
Enter the NPI and taxonomy code for the subpart(s) of the hospital and indicate whether to add or remove the information.

AUTHORIZED SIGNATURE INFORMATION

Element 81 — Signature — Provider
The signature of the individual provider or authorized representative of a clinic or facility provider is required. Signature stamps and electronic signatures are not acceptable.

Element 82 — Date Signed
This is a required field. Enter the month, day, and year (in MM/DD/CCYY format) this form was completed and signed.

ATTACHMENT 2
Provider Change of Address or Status

(A copy of the "Provider Change of Address or Status" is located on the following pages.)

(This page was intentionally left blank.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-01181 (10/12)

STATE OF WISCONSIN

FORWARDHEALTH
PROVIDER CHANGE OF ADDRESS OR STATUS

Instructions: Type or print clearly. Before completing this form, read the Provider Change of Address or Status Completion Instructions, F-01181A. Submit the completed form to ForwardHealth, Provider Enrollment, 313 Blettner Boulevard, Madison, WI 53784.

This form cannot be used to report a change in ownership. Refer to the Online Handbook on the ForwardHealth Portal for instructions.

Contact Provider Services at (800) 947-9627 for more information.

IDENTIFYING INFORMATION (Required)

IMPORTANT
The information in this section is used solely to identify the provider submitting the form and is not intended for updates. Enter information **currently** on file with ForwardHealth in these elements.

1. Name — Provider (Required)	2. Provider ID (Required)	
3. Taxonomy Code (Required for Health Care Providers)	4. ZIP Code (Required)	5. ZIP+4 Extension (Required)

6. Updates on this form are applicable to the following programs. (Required)

- ❑ Wisconsin Medicaid
- ❑ Wisconsin Chronic Disease Program
- ❑ Wisconsin AIDS/HIV Drug Assistance Program
- ❑ Wisconsin Well Woman Program

Note: Sections I-IX should be used to report or change information currently on file with ForwardHealth.

SECTION I — PRACTICE LOCATION INFORMATION

IMPORTANT
Street Address Lines 1 and 2 should not contain any P.O. Box or Lockbox information.

7. Name — Provider		8. National Provider Identifier (NPI)	
9. Street Address Line 1		10. Street Address Line 2	
11. City	12. State	13. ZIP Code	14. ZIP+4 Extension
15. County		16. Telephone Number — For Member Use	
17. Name — Contact Person		18. Telephone Number — Contact Person	

Continued

SECTION II — PROVIDER FINANCIAL INFORMATION

Taxpayer Information

19. Taxpayer Identification Number (TIN)	20. Name — Taxpayer	
21. TIN Type ❑ EIN ❑ SSN	22. TIN Effective Date	23. TIN End Date

Checks and Remittance Advice Address

24. Name — Pay To

25. Address Line 1	26. Address Line 2		
27. City	28. State	29. ZIP Code	30. ZIP+4 Extension
31. Name — Financial Contact Person	32. Telephone Number — Contact Person		

SECTION III — IRS FORM 1099 MAILING ADDRESS

IMPORTANT
Only one 1099 will be sent per TIN. If the provider completing this form is not responsible for receiving the 1099, the provider should not complete this section.

33. Address Line 1	34. Address Line 2		
35. City	36. State	37. ZIP Code	38. ZIP+4 Extension

SECTION IV — MAILING INFORMATION

39. Name — Mail To	40. Name — Attention Line		
41. Address Line 1	42. Address Line 2		
43. City	44. State	45. ZIP Code	46. ZIP+4 Extension

Continued

SECTION V — PRIOR AUTHORIZATION INFORMATION

47. Name — Provider	48. Name — Attention Line
49. Address Line 1	50. Address Line 2

51. City	52. State	53. ZIP Code	54. ZIP+4 Extension

55. Fax Number	56. Telephone Number — Contact Person

SECTION VI — SUPERVISING PROVIDER INFORMATION (For Non-billing Providers Only)

57. Name — Supervisor	58. Telephone Number — Supervisor
59. Address Line 1	60. Address Line 2

61. City	62. State	63. ZIP Code	64. ZIP+4 Extension

65. Effective Date of Supervision

SECTION VII — GENERAL INFORMATION

66. Language(s)
❑ English ❑ Spanish ❑ Other _____
❑ Russian ❑ Hmong

67a. Drug Enforcement Agency (DEA) Number(s)	67b. DEA Number(s)
67c. DEA Number(s)	67d. DEA Number(s)

68. Is the provider Medicare Part A enrolled? ❑ Yes ❑ No Effective Date _____

69. Is the provider Medicare Part B enrolled? ❑ Yes ❑ No Effective Date _____

Continued

SECTION VIII — TAXONOMY

IMPORTANT
A primary taxonomy number must be on file with ForwardHealth at all times. If a primary taxonomy number is being removed, a new one must be indicated.

70. Primary Taxonomy Code

Change the primary taxonomy code on file to the following. _____

❑ Remove old primary taxonomy code from file. ❑ Keep old primary taxonomy code on file as additional code.

71a. Additional Taxonomy Code	71b. ❑ Add ❑ Remove
72a. Additional Taxonomy Code	72b. ❑ Add ❑ Remove
73a. Additional Taxonomy Code	73b. ❑ Add ❑ Remove
74a. Additional Taxonomy Code	74b. ❑ Add ❑ Remove
75a. Additional Taxonomy Code	75b. ❑ Add ❑ Remove

SECTION IX — SUBPART NPI INFORMATION (For Hospital Providers Only)

IMPORTANT
Hospital providers may have identified subparts for their organization and obtained an NPI for those subparts. ForwardHealth programs do not separately certify some hospital subparts such as psychiatric and rehabilitation units; however, the NPI and taxonomy codes of those subparts will be linked to the certified inpatient or outpatient hospital provider file. This enables providers to conduct business with ForwardHealth using NPIs for subparts that ForwardHealth programs do not separately certify.

Enter the NPI and taxonomy code for the subpart(s) of the hospital and indicate whether to add or remove the information.

76a. Subpart NPI	76b. Taxonomy Code	76c. ❑ Add ❑ Remove
77a. Subpart NPI	77b. Taxonomy Code	77c. ❑ Add ❑ Remove
78a. Subpart NPI	78b. Taxonomy Code	78c. ❑ Add ❑ Remove
79a. Subpart NPI	79b. Taxonomy Code	79c. ❑ Add ❑ Remove
80a. Subpart NPI	80b. Taxonomy Code	80c. ❑ Add ❑ Remove

AUTHORIZED SIGNATURE INFORMATION (Required)	
81. **SIGNATURE** — Provider (Required)	82. Date Signed (Required)

For Administrative Use Only

ATTACHMENT 3
Wisconsin AIDS/HIV Drug Assistance Program (ADAP) Formulary, January 1, 2012

(A copy of the "Wisconsin AIDS/HIV Drug Assistance Program [ADAP] Formulary" is located on the following pages.

Wisconsin AIDS/HIV Drug Assistance Program [ADAP] Formulary, January 1, 2012

Antiretrovirals

1. abacavir (Ziagen)
2. atazanavir sulfate (Reyataz)
3. darunavir (Prezista)
4. delavirdine (Rescriptor)
5. didanosine, ddI (Videx, Videx EC)
6. efavirenz (Sustiva)
7. efavirenz, emtricitabine, tenofovir disoproxil fumarate (Atripla)
8. emtricitabine (Emtriva)
9. emtricitabine, tenofovir (Truvada)
10. emtricitabine, tenofovir, rilpivirine (Complera)
11. enfuvirtide (Fuzeon)
12. etravirine, TMC-125 (Intelence)
13. fosamprenavir (Lexiva)
14. indinavir (Crixivan)
15. lamivudine, 3TC (Epivir)
16. lamivudine, abacavir (Epzicom)
17. lopinavir/ritonavir (Kaletra)
18. maraviroc (Selzentry)
19. nelfinavir (Viracept)
20. nevirapine (Viramune)
21. raltegravir (Isentress)
22. rilpivirine, TMC-278 (Edurant)
23. ritonavir (Norvir)
24. saquinavir (Invirase)
25. stavudine, D4T (Zerit)
26. zidovudine, AZT (Retrovir)
27. zidovudine/lamivudine (Combivir)
28. tenofovir disoproxil fumarate (Viread)
29. tipranavir (Aptivus)
30. zidovudine/lamivudine/abacavir (Trizivir)

Other HIV-Related Medications

1. acyclovir (Zovirax)
2. amphotericin B (Fungizone)
3. atovaquone (Mepron)
4. azithromycin (Zithromax)
5. cidofovir (Vistide)
6. clarithromycin (Biaxin)
7. clindamycin (Cleocin)
8. Dapsone
9. ethambutol hydrochloride (Myambutol)
10. famciclovir (Famvir)
11. fluconazole (Diflucan)
12. foscarnet (Foscavir)
13. ganciclovir (Cytovene)
14. ganciclovir implant (Vitrasert)
15. itraconazole (Sporanox)
16. ketoconazole (Nizoral)
17. leucovorin (Wellcovorin)
18. pentamidine (Nebupent)
19. pyrimethamine (Daraprim)
20. rifabutin (Mycobutin)
21. sulfadiazine (Sulfadiazine Tablets)
22. TMP/SMX (Bactrim, Septra)
23. valacylovir hydrochloride (Valtrex)
24. valganciclovir hydrochloride (Valcyte)

Antiretrovial Side Effect Medications

Hyperlipidemia

1. atorvastatin (Lipitor)
2. fenofibrate (Tricor)
3. gemfibrozil (Lopid)
4. niacin (Niaspan)
5. pravastatin (Pravachol)

Neuropathic Pain/Pain

1. amitriptyline (Elavil)
2. gabapentin (Neurontin)

Antidiarrheals

1. diphenoxylate (Lomotil, Lonox)
2. loperamide (Imodium)

Antiemetics

1. prochlorperazine

Hepatitis C Virus Medications

1. interferon alfa-2b (Intron A)
2. interferon/ribavirin (Rebetron)
3. pegylated interferon alfa-2a (Pegasys)
4. pegylated interferon alfa-2b (Peg-Intron)
5. ribavirin (Rebetol, Copegus)

Hepatitis Vaccines

1. Hepatitis A
2. Hepatitis B
3. Twinrix (Combination Hepatitis A & B)

Novel influenza A (H1N1) antivirals

1. oseltamivir (Tamiflu)
2. zanamivir (Relenza)

]

ATTACHMENT 4
Drug Addition Review Request

(A copy of the "Drug Addition Review Request" is located on the following page.

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00020 (10/12)

FORWARDHEALTH
DRUG ADDITION REVIEW REQUEST

Instructions: The use of this form is mandatory to request the review of a National Drug Code (NDC) for addition into a benefit plan.

The completed form may be returned to the Division of Health Care Access and Accountability via fax at (608) 266-1096 or by mail at the following address:

Drug Price File
Division of Health Care Access and Accountability
PO Box 309
Madison WI 53701-0309

SECTION I — PROVIDER INFORMATION

Name — Provider	National Provider Identifier	Taxonomy Code	ZIP+4 Practice Location Code
Name — Contact Person		Telephone Number — Provider	
Address — Provider (Street, City, State, ZIP Code)			

SECTION II — NEW DRUG ADDITIONS

NDC (11 Digit No.)	Drug Name	Dispense Date	Benefit Plan
			❑ Medicaid / BadgerCare Plus Standard Plan / SeniorCare ❑ BadgerCare Plus Benchmark Plan ❑ BadgerCare Plus Core Plan for Childless Adults ❑ BadgerCare Plus Basic Plan ❑ Wisconsin AIDS/HIV Drug Assistance Program (ADAP) ❑ Wisconsin Chronic Disease Program (WCDP), Chronic Renal Disease ❑ WCDP, Adult Cystic Fibrosis ❑ WCDP, Hemophilia Home Care
			❑ Medicaid / BadgerCare Plus Standard Plan / SeniorCare ❑ BadgerCare Plus Benchmark Plan ❑ BadgerCare Plus Core Plan for Childless Adults ❑ BadgerCare Plus Basic Plan ❑ Wisconsin ADAP ❑ WCDP, Chronic Renal Disease ❑ WCDP, Adult Cystic Fibrosis ❑ WCDP, Hemophilia Home Care
			❑ Medicaid / BadgerCare Plus Standard Plan / SeniorCare ❑ BadgerCare Plus Benchmark Plan ❑ BadgerCare Plus Core Plan for Childless Adults ❑ BadgerCare Plus Basic Plan ❑ Wisconsin ADAP ❑ WCDP, Chronic Renal Disease ❑ WCDP, Adult Cystic Fibrosis ❑ WCDP, Hemophilia Home Care

A — Added as Requested; B — Already Added; C — Less-Than-Effective (LTE); D — Not Eligible for Coverage

ATTACHMENT 5
Noncompound Drug Claim Completion Instructions

(A copy of the "Noncompound Drug Claim Completion Instructions" is located on the following pages.)

(This page was intentionally left blank.)

NONCOMPOUND DRUG CLAIM COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible Wisconsin Medicaid, BadgerCare Plus, SeniorCare, Wisconsin AIDS/HIV Drug Assistance Program (ADAP), and Wisconsin Chronic Disease Program (WCDP) 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 (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about ForwardHealth 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 requests, or processing provider claims for reimbursement.

The Noncompound Drug Claim form, F-13072, is used by ForwardHealth and is mandatory when submitting paper claims for noncompound drugs. Failure to supply the information requested by the form may result in denial of payment for the services.

To avoid denial or inaccurate claim payment, use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless “optional” or “not required” is indicated. For Elements 15, 17, 19, 21, 23, and 26, refer to the ForwardHealth Payer Sheet: National Council for Prescription Drug Programs (NCPDP) Version D.0, P-00272, on the ForwardHealth Portal for tables and accepted values.

ForwardHealth members receive an identification card upon being determined eligible. Always verify a member’s enrollment before providing nonemergency services by using Wisconsin’s Enrollment Verification System (EVS) to determine if there are any limitations on covered services. To verify enrollment for ADAP members, providers may submit a real-time claim to ADAP, use the Portal, refer to the letter received from ADAP describing the member’s ADAP coverage, or call ADAP.

For questions regarding these instructions, providers may contact Provider Services at (800) 947-9627.

Note: Submit claims for non-drug items, such as clozapine management services, disposable medical supplies, durable medical equipment, and enteral nutrition products, on the 1500 Health Insurance Claim Form or the 837 Health Care Claim: Professional transaction using nationally recognized five-digit procedure codes.

For Medicaid, BadgerCare Plus, and SeniorCare members, return the form to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

For WCDP members, return the form to the following address:

Wisconsin Chronic Disease Program
PO Box 6410
Madison WI 53716-0410

For ADAP members, return the form to the following address:

ForwardHealth
ADAP Claims and Adjustments
PO Box 8758

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Provider
Enter the name of the billing provider.

Element 2 — National Provider Identifier
Enter the National Provider Identifier (NPI) of the billing provider.

Element 3 — Address — Provider
Enter the address, including the street, city, state, and ZIP+4 code of the billing provider.

SECTION II — MEMBER INFORMATION

Element 4 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters.

Element 5 — Name — Member
Enter the member's name. Use the Enrollment Verification System (EVS) to obtain the correct spelling of the member's name

Element 6 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format (e.g., July 14, 1953, would be 07/14/1953).

Element 7 — Sex — Member
Enter "0" for unspecified, "1" for male, or "2" for female.

Element 8 — Copay Exempt
Indicate whether or not a nursing facility member enrolled in the BadgerCare Plus Standard Plan or Wisconsin Medicaid is exempt from copayment for drugs on the date of discharge from a nursing facility.

SECTION III — CLAIM INFORMATION

Element 9 — Prescriber Number
Enter a valid NPI for the prescriber.

Element 10 — Date Prescribed
Enter the date shown on the prescription in MM/DD/CCYY format.

Element 11 — Date Filled
Enter the date that the prescription was filled or refilled in MM/DD/CCYY format.

Element 12 — Refill
Enter the refill indicator. The first two digits of the refill indicator is the refill being billed. This must be "00" if the date prescribed equals the date filled. The second element is the total refills allowed (e.g., the second refill of a six-refill prescription would be "02/06.") A non-refillable prescription would be "00/00." Enter "99" in the second element if the prescription indicates an unlimited number of refills.

Element 13 — NDC
Enter the 11-digit National Drug Code (NDC) or the ForwardHealth-assigned 11-digit procedure code for the item being billed. (Use the NDC indicated on the product.)

Element 14 — Days' Supply
Enter the days' supply of medication that has been dispensed for the member. This must be a whole number greater than zero (e.g., if a prescription is expected to last for five days, enter "5").

Element 15 — 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 16 — Prescription Number
Enter the prescription number. Each drug billed must have a unique prescription number.

Element 17 — Drug Description (Optional)

Element 18 — Special Packaging Indicator
Enter a value of "4" (custom packaging) or "5" (multi-drug compliance packaging) to indicate that repackaging has occurred for non-unit dose drugs. Any other valid value indicated in this field will not be used to determine reimbursement for repackaging.

Element 19 — Dispense As Written
Enter the appropriate one-digit NCPDP Dispense As Written (DAW) code. Refer to the payer sheet for a list of DAW codes.

Element 20 — Place of Service
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Element 21 — Diagnosis Code
This element is required when billing for a drug for which ForwardHealth requires a diagnosis or when billing for Pharmaceutical Care (PC) services. If the diagnosis of the drug is different from that of the PC services, enter the diagnosis code of the drug from the *International Classification of Diseases, Ninth Revision, Clinical Modification* coding structure. Enter all digits of the diagnosis code, including the preceding zeros.

Element 22 — Level of Effort
This element is required when billing for PC services. Refer to the Pharmacy service area of the ForwardHealth Online Handbook for PC information. Enter the NCPDP code that corresponds with the time required to perform the PC service. Refer to the payer sheet for a list of level of effort codes.

Element 23 — Reason for Service
This element is required when billing for Drug Utilization Review (DUR) or PC services. Refer to the Pharmacy service area of the ForwardHealth Online Handbook for DUR and PC information and the payer sheet for applicable PC values.

Element 24 — Professional Service
This element is required when billing for DUR or PC services. Refer to the Pharmacy service area of the ForwardHealth Online Handbook for DUR and PC information and the payer sheet for applicable PC values.

Element 25 — Result of Service
This element is required when billing for DUR or PC services. Refer to the Pharmacy service area of the ForwardHealth Online Handbook for DUR and PC information and the payer sheet for applicable PC values.

Element 26 — Other Coverage Code
ForwardHealth is usually the payer of last resort for program-covered services. (Refer to the Pharmacy service area of the ForwardHealth Online Handbook for more information about Coordination of Benefits.) Prior to submitting a claim to ForwardHealth, providers are required to verify whether a member has other health insurance coverage (e.g., commercial health insurance, HMO, or Medicare).

If a member has Medicare and other insurance coverage, the provider is required to bill both prior to submitting a claim to ForwardHealth. Enter one of the NCPDP other coverage (OC) codes that best describe the member's situation. Refer to the payer sheet for a list of other coverage codes.

Element 27 — Charge
Enter the total charges for this claim.

Element 28 — Other Coverage Amount
When applicable, enter the amount paid by commercial health insurance. This is required when the OC code in Element 26 indicates "2."

Note: Pharmacies may also include the Medicare-paid amount in this field for claims that fail to automatically crossover from Medicare to ForwardHealth within 30 days.

Element 29 — Patient Paid Amount
When applicable for SeniorCare claims, enter the member's out-of-pocket expense due to OC, including Medicare Part B or D and/or commercial health insurance. Do not enter an expected copayment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, ADAP, or WCDP.

Element 30 — Net Billed
Enter the balance due by subtracting the OC amount and the patient paid amount from the amount in Element 27.

Element 31 — Certification
The provider is required to read the certification information of the form. By signing and dating Element 32 and Element 33, the provider attests to the certification information in Element 31.

Element 32 — Signature — Pharmacist or Dispensing Physician
The pharmacist or dispensing physician is required to complete and sign this form.

Note: The signature may be computer generated or stamped.

Element 33 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

ATTACHMENT 6
Noncompound Drug Claim

(A copy of the "Noncompound Drug Claim" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-13072 (10/12)

STATE OF WISCONSIN
DHS 106.03(1), Wis. Admin. Code

NONCOMPOUND DRUG CLAIM

Instructions: Type or print clearly. Before completing this form, read the Noncompound Drug Claim Completion Instructions, F-13072A.

For questions, contact Provider Services at (800) 947-9627. For ForwardHealth members, return the completed form to: ForwardHealth, Claims and Adjustments, 313 Blettner Boulevard, Madison, WI 53784.

For Wisconsin Chronic Disease Program members, return form to: ForwardHealth, P.O. Box 6410, Madison, WI 53716-0410.

For Wisconsin AIDS/HIV Drug Assistance Program members, return form to: ForwardHealth, ADAP Claims and Adjustments, P.O. Box 8758, Madison, WI 53708.

SECTION I — PROVIDER INFORMATION

1. Name — Provider	2. National Provider Identifier

3. Address — Provider (Street, City, State, ZIP+4 Code)

SECTION II — MEMBER INFORMATION

4. Member Identification Number	5. Name — Member (Last, First, Middle Initial)	6. Date of Birth — Member	7. Sex — Member	8. Copay Exempt

SECTION III — CLAIM INFORMATION

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. NDC	14.Days'Supply

15. Quantity	16. Prescription Number	17. Drug Description

18. Special Package Indicator	19. Dispense as Written	20. Place of Service	21. Diagnosis Code

22. Level of Effort	23.Reason for Service	24.Professional Service	25. Result of Service

26. Other Coverage Code	27. Charge	28. Other Coverage Amount	29. Patient Paid Amount	30. Net Billed
	$	**$**	**$**	**$**

31. Certification

I certify the services and items for which reimbursement is claimed on this claim form were provided to the previously named member pursuant to the prescription of a licensed physician, podiatrist, or dentist. Charges on this claim form do not exceed my (our) usual and customary charge for the same services or items when provided to persons not entitled to receive benefits under ForwardHealth.

I understand that any payment made in satisfaction of this claim will be derived from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be subject to prosecution under applicable federal or state law.

32. SIGNATURE — Pharmacist or Dispensing Physician	33. Date Signed

F-13072

ATTACHMENT 7
Coordination of Benefits Examples for ADAP

The following table lists coordination of benefits examples for Wisconsin AIDS/HIV Drug Assistance Program claim submissions.

Coordination of Benenfits Examples for Wisconsin AIDS/HIV Drug Assistance Program (ADAP)					
		ADAP and Medicare Part D		ADAP and Commercial Health Insurance	
NCPDP Fields		PAID	DENIED	PAID	DENIED
Field Number	Field Name				
308-C8	Other Coverage Code	2	3	2	3
337-4C	Other Payments Count	1	1	1	1
338-5C	Other Payer Coverage Type	01	01	01	01
339-6C	Other Payer ID Qualifier	99	99	99	99
340-7C	Other Payer ID	PARTD	PARTD	COMM	COMM
426-DQ	Usual And Customary Charge	$40.00	$40.00	$75.00	$75.00
430-DU	Gross Amount Due	$40.00	$40.00	$75.00	$75.00
443-E8	Other Payer Date	20111016	20111016	20111016	20111016
341-HB	Other Payer Amount Paid Count	1		1	
342-HC	Other Payer Amount Paid Qualifier	07		07	
431-DV	Other Payer Amount Paid	$25.00		$40.00	
471-5E	Other Payer Reject Count		2		2
472-6E	Other Payer Reject Code		7G, 70		7Z,8K
353-NR	Other Payer-Patient Responsibility Count	01		01	
351-NP	Other Payer-Patient Responsibility Qualifier	06		06	
352-NQ	Other Payer-Patient Responsibility	$15.00		$15.00	
104-A4	Processor Control Number	WIPARTD	WIPARTD		

ATTACHMENT 8
Provider Services and Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

ForwardHealth Portal	***www.forwardhealth.wi.gov/***	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**(800) 947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth Automated Voice Response system, provides responses to the following inquiries: • Checkwrite. • Claim status. • Prior authorization. • Member enrollment.		
ForwardHealth Provider Services Call Center	**(800) 947-9627**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist providers in the following programs: • BadgerCare Plus. • Medicaid. • SeniorCare. • Wisconsin Well Woman Medicaid. • Wisconsin Chronic Disease Program (WCDP). • Wisconsin Well Woman Program (WWWP). • Wisconsin Medicaid and BadgerCare Plus Managed Care Programs.		
ForwardHealth Portal Helpdesk	**(866) 908-1363**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**(866) 416-4979**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)***
For providers, trading partners, billing services, and clearinghouses with technical questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software.		
Managed Care Ombudsman Program	**(800) 760-0001**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		

Member Services	**(800) 362-3002**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		
Wisconsin AIDS/HIV Drug Assistance Program (ADAP)	**(800) 991-5532**	**Monday through Friday, 8:00 a.m. to 4:30 p.m. (Central Standard Time)***
To assist ADAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

ATTACHMENT 9
Timely Filing Exceptions

The following tables list timely filing deadlines and documentation requirements as they correspond to each of the four allowable timely filing exceptions for the Wisconsin AIDS/HIV Drug Assistance Program.

Denial Due to Discrepancy Between the Member's Enrollment Information in ForwardHealth interChange and the Member's Actual Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim is initially received by the deadline but is denied due to a discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.	To receive consideration, a copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation.	ForwardHealth ADAP Timely Filing PO Box 8758 Madison WI 53708

ADAP Reconsideration or Recoupment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when ADAP reconsiders a previously processed claim. Wisconsin ADAP will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the Remittance Advice (RA) message. A copy of the RA message that shows the ADAP-initiated adjustment must be submitted with the request.	ForwardHealth ADAP Timely Filing PO Box 8758 Madison WI 53708

Medicare Denial Occurs After the Submission Deadline		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: • The charges were previously submitted to Medicare. • The member name and identification number do not match. • The services were previously denied by Medicare.	To receive consideration, the following must be submitted within 90 days of the Medicare processing date: • A copy of the Medicare remittance information. • The appropriate Medicare disclaimer code must be indicated on the claim.	ForwardHealth ADAP Timely Filing PO Box 8758 Madison WI 53708

• The provider retroactively applied for Medicare enrollment and did not become enrolled.		

Refund Request from an Other Health Insurance Source		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the following documentation must be submitted within 90 days from the date of recoupment notification: • A copy of the commercial health insurance remittance information. • A copy of the remittance information showing recoupment for crossover claims when Medicare is recouping payment.	ForwardHealth ADAP Timely Filing PO Box 8758 Madison WI 53708

ATTACHMENT 10
Responding to ADAP Within 120 Days of Provider-Based Billing

The following table provides information about responding to the Wisconsin AIDS/HIV Drug Assistance Program (ADAP) within 120 days of the date on the Provider-Based Billing Summary.

Responding to ADAP Within 120 Days		
Scenario	**Documentation Requirements**	**Submission Address**
The provider discovers through enrollment verification methods that ADAP has removed or enddated the other health insurance coverage from the member's file.	• The Provider-Based Billing Summary. • Indication on enrollment verification methods no longer reports the member's other coverage.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported through enrollment verification methods is invalid.	• The Provider-Based Billing Summary. • One of the following: o The name of the person with whom the provider spoke and the member's correct other coverage information. o A printed page from an enrollment Web site containing the member's correct other coverage information.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• The Provider-Based Billing Summary. • A copy of the remittance information received from the other health insurance source. • The date of service (DOS), other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary. *Note:* In this situation, ADAP will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). Refund checks should not be sent. Payment will be withheld from reimbursement applied after 120 days. After 120 days, payment will be adjusted for future claims.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288

Responding to ADAP Within 120 Days (Continued)		
Scenario	**Documentation Requirements**	**Submission Address**
The other health insurance source denies the provider-based billing claim.	• The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: o Remittance information from the other health insurance source. o A letter from the other health insurance source indicating a policy termination date that precedes the DOS. o Documentation indicating that the other health insurance source paid the member. o A copy of the insurance card or other documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage. • The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288
The other health insurance source fails to respond to the initial *and* follow-up provider-based billing claim.	• The Provider-Based Billing Summary. • Indication that no response was received by the other health insurance source. • Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288

ATTACHMENT 11
Responding to ADAP Within and Beyond Provider-Based Billing Deadlines

The following tables provide information about responding to the Wisconsin AIDS/HIV Drug Assistance Program (ADAP) within and beyond provider-based billing claim submission deadlines.

Responding to ADAP Within Claims Submission Deadlines		
Scenario	**Documentation Requirements**	**Submission Address**
The provider discovers through enrollment verification methods that ADAP has removed or enddated the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim).	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported through enrollment verification methods is invalid.	• An Other Coverage Discrepancy Report form, F-01159 (09/12). • A claim according to normal claims submission procedures after verifying that the member's other coverage information has been updated (do not use the prepared provider-based billing claim).	Send the Other Coverage Discrepancy Report form to the address indicated on the form. Send the claim to the following address: Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • The amount received from the other health insurance source.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288
The other health insurance source denies the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288

Responding to ADAP Within Claims Submission Deadlines (Continued)		
Scenario	**Documentation Requirements**	**Submission Address**
The commercial health insurance carrier does not respond to an initial *and* follow-up provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288
Responding to ADAP Beyond Claims Submission Deadlines		
Scenario	**Documentation Requirements**	**Submission Address**
The provider discovers through enrollment verification methods that ADAP has removed or enddated the other health insurance coverage from the member's file.	• A claim (do not use the prepared provider-based billing claim). • A Timely Filing Appeals Request form, F-13047 (07/12), according to normal timely filing appeals procedures.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported through enrollment verification methods is invalid.	• An Other Coverage Discrepancy Report form. • After using enrollment verification methods to verify that the member's other coverage information has been updated, include both of the following: o A claim (do not use the prepared provider-based billing claim.) o A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Send the Other Coverage Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following address: Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288
The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	• A claim (do not use the prepared provider-based billing claim). • Indicate the appropriate other insurance indicator. • Indicate the amount received from the commercial insurance. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288

Responding to ADAP Beyond Claims Submission Deadlines (Continued)		
Scenario	**Documentation Requirements**	**Submission Address**
The other health insurance source denies the provider-based billing claim.	• A claim (do not use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. • The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: o Remittance information from the other health insurance source. o A written statement from the other health insurance source identifying the reason for denial. o A letter from the other health insurance source indicating a policy termination date that proves that the other health insurance source paid the member. o A copy of the insurance card or other documentation from the other health insurance source that indicates that the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage only. • The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288
The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	• A claim (do not use the prepared provider-based billing claim). • The appropriate other insurance indicator. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Division of Public Health Wisconsin ADAP PO Box 2659 Madison WI 53701-2659 Fax (608) 266-1288