Information in this *ForwardHealth Update* has changed. ForwardHealth is postponing the Explanation of Medical Benefits form, F-01234 (11/14), requirement until further notice. Other insurance on the UB-04 claim form should be submitted as it was prior to the introduction of the Explanation of Medical Benefits form. Refer to *Update* 2014-76, titled "ForwardHealth Is Postponing the Explanation of Medical Benefits Form Requirement for Paper Claims and Paper Claim Adjustments with Other Health Insurance Indicated," for current information.

ForwardHealth
Wisconsin serving you

October 2014

No. 2014-61

Affected Programs: BadgerCare Plus, Medicaid, Wisconsin Chronic Disease Program
To: All Providers, HMOs and Other Managed Care Programs

New Requirements for Paper Claims and Paper Claim Adjustments with Other Health Insurance Indicated

This *ForwardHealth Update* announces new requirements for professional and institutional paper claims and paper claim adjustments when other health insurance sources (e.g., commercial insurance, Medicare) are indicated on the claim or adjustment. Effective for paper claims and adjustments received on and after November 12, 2014, regardless of date of service or date of discharge, if applicable, a new Explanation of Medical Benefits form, F-01234 (11/14), must be included for each other payer indicated on the claim or adjustment.

New Explanation of Medical Benefits Form Required

This *ForwardHealth Update* announces new requirements for professional and institutional paper claims and paper claim adjustments submitted on paper when other health insurance sources (e.g., commercial insurance, Medicare) are indicated on the claim or adjustment. Effective for paper claims and adjustments received on and after November 12, 2014, regardless of date of service (DOS) or date of discharge, if applicable, a new Explanation of Medical Benefits form, F-01234 (11/14), must be included for each other payer indicated on the claim or adjustment.

Note: Dental claims and claim adjustments and compound and noncompound drug claims and claim adjustments are *not* subject to the new requirements regarding use of the Explanation of Medical Benefits form.

Paper claims or adjustments that have other health insurance indicated will be returned to the provider unprocessed if they are submitted without the new Explanation of Medical Benefits form for each other payer. Paper claims or adjustments submitted with incorrect or incomplete Explanation of Medical Benefits forms will also be returned.

Copies of the new Explanation of Medical Benefits form and instructions are included in Attachments 1 and 2 of this *Update*. They may also be found on the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/content/provider/forms/index.htm.spage*.

Use of the ForwardHealth Explanation of Medical Benefits form is mandatory; providers are required to use an exact copy. ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of the Explanation of Medical Benefits form.

ForwardHealth is changing the requirements for paper claims and adjustments to ensure consistency with electronic claims and adjustments submitted via the ForwardHealth Portal or using an 837 Health Care Claim transaction (including those submitted using Provider Electronic Solutions software or through a clearinghouse or software vendor).

These new requirements apply to paper claims and adjustments submitted to Wisconsin Medicaid, BadgerCare Plus, and the Wisconsin Chronic Disease Program (WCDP). Providers are reminded that, except for a few instances, Wisconsin Medicaid, BadgerCare Plus, and WCDP are payers of last resort for any covered service. Therefore, providers are required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to ForwardHealth or to a state-contracted managed care organization (MCO).

Wisconsin Medicaid and BadgerCare Plus are *not* payers of last resort for members who receive coverage from certain governmental programs, including the following:

- Birth to 3.
- Crime Victim Compensation Fund.
- General Assistance.
- Home and Community-Based Services waiver programs.
- Individuals with Disabilities Education Act.
- Indian Health Service.
- Maternal and Child Health Services.
- Wisconsin Chronic Disease Program, which includes the following:
  - ✓ Adult Cystic Fibrosis.
  - ✓ Chronic Renal Disease.
  - ✓ Hemophilia Home Care.

Providers should ask members if they have coverage from these other governmental programs.

If the member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus, providers who have already been reimbursed by one of these government programs may be required to submit the claims to ForwardHealth and refund the payment from the government program.

Impacted Paper Claim Forms

The Explanation of Medical Benefits form will be required with all of the following paper claim forms if other health insurance sources are indicated:

- 1500 Health Insurance Claim Forms and adjustments.
- UB-04 Claim Forms and adjustments.
- 1500 and UB-04 claims and adjustments submitted with a Timely Filing Appeals Request form, F-13047 (07/12).
- 1500 and UB-04 claims and adjustments that require special handling.
- Medicare crossover claims.

Note: Effective November 12, 2014, ForwardHealth will no longer accept the 1500 Health Insurance Claim Form, version August 2005 (08/05). Regardless of the DOS or date of discharge, as applicable, indicated on the claim, ForwardHealth will only accept the National Uniform Claim Committee-developed and Centers for Medicare and Medicaid Services-adopted paper 1500 Health Insurance Claim Form, version February 2012 (02/12). The 1500 Health Insurance Claim Form dated February 2012 (02/12) will replace the 1500 Health Insurance Claim Form dated August 2005 (08/05). For more information, refer to the October 2014 *Update* (2014-62), titled "Changes to the 1500 Health Insurance Claim Form and Completion Instructions."

Reminder Regarding Ink, Data Alignment, and Quality Standards for Paper Claim Submission

In order for Optical Character Recognition software to read paper claim forms accurately, the claim forms must comply with certain ink standards, as well as other data alignment and quality standards. The new Explanation of Medical Benefits form will also need to comply with these standards. Refer to the Paper Claim Form Preparation and Data Alignment Requirements topic (topic #561) in the Submission chapter of the Claims section of the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov/* for more information.

Information That Will No Longer Be Required to Be Completed on Claim Forms

With implementation of the new Explanation of Medical Benefits form, certain elements and form locators that were previously required to be completed on the 1500 Health

Insurance Claim Form and the UB-04 Claim Form, respectively, will no longer be required; the information will instead be required to be provided on the Explanation of Medical Benefits form. In addition, certain information that was previously required on provider-submitted paper crossover claims will no longer be required.

Elements That Will No Longer Be Required Fields on the 1500 Health Insurance Claim Form

The following elements will no longer be required fields on the 1500 Health Insurance Claim Form due to implementation of the new Explanation of Medical Benefits form:

- **Element 9 — Other Insured's Name** — Other insurance (OI) explanation codes OI-P, OI-D, and OI-Y should no longer be indicated in Element 9 on the 1500 Health Insurance Claim Form. The applicable OI explanation code must be provided on the Explanation of Medical Benefits form instead — in Element 11 (Paid/Deny) if the primary payer processed the claim at the header level or in Element 25 (Paid/Deny) if the primary payer processed the claim at the detail level.
- **Element 11 — Insured's Policy Group or FECA Number** — Medicare disclaimer codes M-7 and M-8 should no longer be indicated in Element 11 on the 1500 Health Insurance Claim Form. The applicable Medicare disclaimer code must be provided on the Explanation of Medical Benefits form instead — in Element 11 if the primary payer processed the claim at the header level or in Element 25 if the primary payer processed the claim at the detail level.
- **Element 29 — Amount Paid** — If the primary payer processed the claim at the header level, the total amount paid by the primary payer for the entire claim must be provided in Element 14 (Paid) on the Explanation of Medical Benefits form; if the primary payer processed the claim at the detail level, the total amount paid by the primary payer for the applicable detail must be provided in Element 30 (Paid) on the Explanation of Medical Benefits form.

Form Locators That Will No Longer Be Required Fields on the UB-04 Claim Form

The following form locators will no longer be required fields on the UB-04 Claim Form due to implementation of the new Explanation of Medical Benefits form:

- **Form Locator 54 A-C — Prior Payments** — If the primary payer processed the claim at the header level, the total amount paid by the primary payer for the entire claim must be provided in Element 14 on the Explanation of Medical Benefits form; if the primary payer processed the claim at the detail level, the total amount paid by the primary payer for the applicable detail must be provided in Element 30 on the Explanation of Medical Benefits form.
- **Form Locator 80 — Remarks** — Other insurance explanation codes OI-P, OI-D, and OI-Y and Medicare disclaimer codes M-7 and M-8 should no longer be indicated in Form Locator 80 on the UB-04 Claim Form. The applicable OI explanation code or Medicare disclaimer code must be provided on the Explanation of Medical Benefits form instead — in Element 11 if the primary payer processed the claim at the header level or in Element 25 if the primary payer processed the claim at the detail level.

Information That Will No Longer Be Required on Provider-Submitted Paper Crossover Claims

Providers will no longer be required to indicate MMC in the upper right corner of provider-submitted paper crossover claims for services provided to members enrolled in a Medicare Advantage Plan. Element 1 on the new Explanation of Medical Benefits form will capture this information.

Revised Claim Form Completion Instructions

ForwardHealth will be revising the 1500 Health Insurance Claim Form completion instructions and the UB-04 Claim Form completion instructions in the applicable service areas of the Online Handbook to align with the new requirements for claims and adjustments with other health insurance

information indicated. The updated completion instructions will be available in the Online Handbook in November 2014.

Services Not Requiring Commercial Health Insurance Billing

As a reminder, providers are *not* required to bill commercial health insurance sources before submitting claims for the following:

- Case management services.
- Community recovery services.
- Community support program services.
- Comprehensive community services.
- Crisis intervention services.
- Family planning services.
- Personal care services.
- Prenatal care coordination services.
- Preventive pediatric services.
- Specialized medical vehicle services.

Information Regarding Managed Care Organizations

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

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

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

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

P-1250

ATTACHMENT 1
Explanation of Medical Benefits Form Completion Instructions

(A copy of the "Explanation of Medical Benefits Completion Instructions" is located on the following pages.)

(This page was intentionally left blank.)

FORWARDHEALTH
EXPLANATION OF MEDICAL BENEFITS COMPLETION INSTRUCTIONS

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

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

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

The use of this form is mandatory when submitting claim information for other health insurance. Alternate versions will not be accepted.

Providers may submit the completed Explanation of Medical Benefits form, F-01234, with a completed paper claim form by mail to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Providers are required to retain a copy of the completed form in the member's records.

INSTRUCTIONS
Providers are required to submit a separate Explanation of Medical Benefits form for each payer that has processed the claim prior to ForwardHealth (also known as a "primary payer"). Primary payers may be Medicare, Medicare Advantage, or commercial insurance.

Explanation of Medical Benefits forms for up to five different primary payers will be allowed for each claim. Each Explanation of Medical Benefits form allows for up to 12 details of explanation of benefits (EOB) information to be added *for a single primary payer*. Additional Explanation of Medical Benefits forms can be attached, as follows:

- First Explanation of Medical Benefits form — complete all sections of the form (both front and back).
- Additional Explanation of Medical Benefits forms for the same payer — complete Section I; Section II, Element 3; and Section V. Leave Sections III and IV blank.

Note: When indicating negative numbers on the Explanation of Medical Benefits form, providers are required to place the hyphen in front of the number that is being indicated as negative. Providers may *not* use a hyphen following the number or parenthesis around the number to indicate that it is negative as the information will not be captured correctly.

SECTION I — PAYER INFORMATION
Element 1 is a required element.

Element 1
Check the appropriate box to indicate whether the primary payer is Medicare, Medicare Advantage, or commercial insurance. If commercial insurance, enter the name of the commercial insurance, if known, in the space provided.

Check *one* box only. If more than one box is checked in Element 1 on the Explanation of Benefits form, the claim will be returned to the provider unprocessed.

SECTION II — MEMBER INFORMATION
Elements 2 through 4 are required elements.

Element 2 — Name — Member
Enter the last name, first name, and middle initial of the member.

Element 3 — Member ID / HICN
Enter the 10-digit Medicaid member ID. This number must correspond to the member ID on the 1500 Health Insurance Claim Form or UB-04 (CMS 1450) Claim Form as well as any additional Explanation of Medical Benefits forms. If the details continue onto page 2 of the Explanation of Medical Benefits form, enter the member ID listed in this element in the space provided at the top of the page.

Element 4 — Relationship to Policyholder
Indicate the member's relationship to the policyholder using the following codes.

Code	Relationship
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ donor
40	Cadaver donor
53	Life partner
G8	Other relationship

SECTION III — PRIMARY POLICYHOLDER INFORMATION

Elements 5 through 7 are required elements.

Element 5 — Name — Primary Policyholder
Enter the name of the primary payer policyholder.

Element 6 — Primary Policy ID / HICN
Enter the primary payer policyholder's identification number or Health Insurance Claim Number.

Element 7 — Policy / Group Number
Enter the primary payer policyholder's policy or group number.

SECTION IV — HEADER ADJUDICATION INFORMATION

Providers are required to complete this section if the primary payer processed the claim at the header level. If the primary payer did not supply header-level information, this section may be left blank. If this section is left blank, providers are required to complete Section V. The claim will be returned to the provider unprocessed if both Sections IV and V on the Explanation of Medical Benefits form are left blank.

If explanation code Y or Medicare code 8 is indicated in Element 11, then Element 8 and Elements 12 through 21 may be left blank.

Element 8 — Date Payer Processed
Enter the date the primary payer processed the claim in MMDDCCYY format.

Element 9 — From Date of Service
Enter the From date of service (DOS) in MMDDCCYY format.

Element 10 — To Date of Service
Enter the To DOS in MMDDCCYY format.

Element 11 — Paid / Deny
Primary payers must be billed prior to submitting claims to ForwardHealth, unless the service does not require primary payer billing as determined by ForwardHealth.

If Wisconsin's Enrollment Verification System (EVS) indicates that the member has any primary payer, and the service requires primary payer billing, one of the following must be indicated in Element 11:

- Non-dental providers — If the EVS indicates that the member has dental ("DEN") insurance only, then an Explanation of Medical Benefits form is not required with the claim. If the EVS indicates that the member has any other commercial health insurance, and the service requires other insurance billing, then one of the explanation codes from the following table must be indicated in Element 11 on the Explanation of Medical Benefits form.
- Dental providers — Commercial health insurance or dental insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth. Commercial health insurance coverage is indicated by the EVS under Other Commercial Health Insurance. ForwardHealth has identified specific *Current Dental Terminology* (CDT) procedure codes that must be billed to other insurance sources prior to being billed to ForwardHealth. Additionally, ForwardHealth has defined a set of Other Insurance (OI) indicators for dental (refer to the Commercial Health Insurance chapter of the Coordination of Benefits section in the Dental service area of the ForwardHealth Online Handbook).

All Primary Payers	
Code	**Description**
P	PAID in part or in full by any primary payer (Medicare, Medicare Advantage, or commercial insurance).
Commercial Insurance Payers Only	
Code	**Description**
D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied toward the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following: • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.
Note: The provider may not use explanation code D or Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill ForwardHealth for services that are included in the capitation payment.	

Medicare Primary Payers — An Explanation of Medical Benefits form is *not* required for Medicare when one or more of the following statements is true:

- Medicare does not cover the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage, including a Medicare Advantage Plan, for the service provided (e.g., the service is covered by Medicare Part A, but the member does not have Medicare Part A).
- ForwardHealth indicates that the provider is not Medicare-enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medical Benefits form but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, the Explanation of Medical Benefits form is required and a Medicare disclaimer code is necessary.

Medicare or Medicare Advantage Payers Only	
Code	**Description**
7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness (SOI), or yearly allotment of available benefits is exhausted. For Medicare Part A, use code 7 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. For Medicare Part B, use code 7 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.

Medicare or Medicare Advantage Payers Only (Continued)	
Code	**Description**
8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. For Medicare Part A, use code 8 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis). For Medicare Part B, use code 8 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Element 12 — Billed Amount
Enter the total billed amount from the claim form being submitted.

Element 13 — Allowed
Enter the amount allowed by the primary payer.

Element 14 — Paid
If explanation code P is indicated in Element 11, enter the total amount paid by the primary payer for the entire claim. If explanation code D or Y or Medicare code 7 or 8 is indicated in Element 11, enter zero.

Element 15 — Coins PR 2
If the primary payer EOB indicates coinsurance (PR 2), enter the total primary payer coinsurance amount for the claim.

Element 16 — Deductible PR 1
If the primary payer EOB indicates deductible (PR 1), enter the total primary payer deductible amount for the claim.

Element 17 — Noncovered CO 96
If the primary payer EOB indicates noncovered (CO 96), enter the total primary payer noncovered amount for the claim.

Element 18 — Copay PR 3
If the primary payer EOB indicates copayment (PR 3), enter the total primary payer copayment amount for the claim.

Element 19 — Blood Deduct PR 66
If the primary payer EOB indicates blood deductible (PR 66), enter the total primary payer blood deductible amount for the claim.

Element 20 — Psych Reduct PR 122
If the primary payer EOB indicates psychiatric reduction (PR 122), enter the total primary payer psychiatric reduction amount for the claim.

Element 21 — ANSI Reason Codes
If the primary payer EOB indicates any other American National Standards Institute (ANSI) reason codes not included in Elements 15 through 20, enter the additional ANSI reason codes and their dollar amounts as indicated by the primary payer.

If the sum of Elements 13 through 20 does *not* equal the billed amount indicated in Element 12, the difference must be accounted for in this element.

Note: When indicating the ANSI reason group code (e.g., CO PR), providers should *not* use a hyphen between the reason group code and the ANSI reason code, or the system may interpret the ANSI reason code as a negative number (e.g., rather than indicating CO-45, providers should indicate CO 45).

SECTION V — DETAIL ADJUDICATION INFORMATION

Providers are required to complete this section if the primary payer processed the claim at the detail level. If the primary payer did not supply detail-level information, providers may leave this section blank. If this section is left blank, providers are required to complete Section IV. The claim will be returned to the provider unprocessed if both Sections IV and V on the Explanation of Medical Benefits form are left blank.

If explanation code Y or Medicare code 8 is indicated in Element 25, then Element 22 and Elements 26 through 37 may be left blank.

Enter a detail number in the first column for each detail line on the claim form and complete Elements 22 through 37 as they correspond to the details on the claim form. If the details continue onto page 2 of the Explanation of Medical Benefits form, enter the member ID from Element 3 of the Explanation of Medical Benefits form in the space provided at the top of the page.

Element 22 — Date Payer Processed
Enter the date the primary payer processed the claim in MMDDCCYY format.

Element 23 — From Date of Service
Enter the From DOS in MMDDCCYY format.

Element 24 — To Date of Service
Enter the To DOS in MMDDCCYY format.

Element 25 — Paid / Deny
Primary payers must be billed prior to submitting claims to ForwardHealth, unless the service does not require primary payer billing as determined by ForwardHealth.

If the EVS indicates that the member has any primary payer, and the service requires primary payer billing, one of the following must be indicated in Element 25:

- Non-dental providers — If the EVS indicates that the member has dental ("DEN") insurance only, then an Explanation of Medical Benefits form is not required with the claim. If the EVS indicates that the member has any other commercial health insurance, and the service requires other insurance billing, then one of the explanation codes from the following table must be indicated in Element 25 of the Explanation of Medical Benefits form.
- Dental providers — Commercial health insurance or dental insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth. Commercial health insurance coverage is indicated by the EVS under Other Commercial Health Insurance. ForwardHealth has identified specific CDT procedure codes that must be billed to other insurance sources prior to being billed to ForwardHealth. Additionally, ForwardHealth has defined a set of OI indicators for dental (refer to the Commercial Health Insurance chapter of the Coordination of Benefits section in the Dental service area of the ForwardHealth Online Handbook).

All Primary Payers	
Code	**Description**
P	PAID in part or in full by any primary payer (Medicare, Medicare Advantage, or commercial insurance).
Commercial Insurance Payers Only	
Code	**Description**
D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied toward the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following: • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.
Note: The provider may not use explanation code D or Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill ForwardHealth for services that are included in the capitation payment.	

Medicare Primary Payers — An Explanation of Medical Benefits form is *not* required for Medicare when one or more of the following statements are true:

- Medicare does not cover the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage, including a Medicare Advantage Plan, for the service provided (e.g., the service is covered by Medicare Part A, but the member does not have Medicare Part A).
- ForwardHealth indicates that the provider is not Medicare-enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medical Benefits form but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, the Explanation of Medical Benefits form is required and a Medicare disclaimer code is necessary.

Medicare or Medicare Advantage Payers Only	
Code	**Description**
7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, SOI, or yearly allotment of available benefits is exhausted. For Medicare Part A, use code 7 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. For Medicare Part B, use code 7 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. For Medicare Part A, use code 8 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis). For Medicare Part B, use code 8 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Element 26 — Billed Amount
Enter the primary payer amount billed on the detail.

Element 27 — Proc. Code
Enter the procedure code from the detail, if applicable.

Element 28 — Revenue Code
Enter the revenue code from the detail, if applicable.

Element 29 — Allowed
Enter the primary payer allowed amount from the detail.

Element 30 — Paid
If explanation code P is entered in Element 25, enter the total amount paid by the primary payer for that detail. If explanation code D or Y or Medicare code 7 or 8 is indicated in Element 25, enter zero.

Element 31 — Coins PR 2
If the primary payer EOB indicates coinsurance (PR 2), enter the primary payer coinsurance amount for the detail.

Element 32 — Deductible PR 1
If the primary payer EOB indicates deductible (PR 1), enter the primary payer deductible for the detail.

Element 33 — Noncovered CO 96
If the primary payer EOB indicates noncovered (CO 96), enter the primary payer noncovered amount for the detail.

Element 34 — Copay PR 3
If the primary payer EOB indicates copayment (PR 3), enter the primary payer copayment for the detail.

Element 35 — Blood Deduct PR 66
If the primary payer EOB indicates blood deductible (PR 66), enter the primary payer blood deductible amount for the detail.

Element 36 — Psych Reduct PR 122
If the primary payer EOB indicates psychiatric reduction (PR 122), enter the primary payer psychiatric reduction amount for the detail.

Element 37 — ANSI Reason Codes
If the primary payer EOB indicates any other ANSI reason codes not included in Elements 31 through 36, enter the additional ANSI reason codes and their dollar amounts as indicated by the primary payer.

If the sum of Elements 29 through 36 does *not* equal the billed amount indicated in Element 26, the difference must be accounted for in this element.

Note: When indicating the ANSI reason group code (e.g., CO PR), providers should *not* use a hyphen between the reason group code and the ANSI reason code, or the system may interpret the ANSI reason code as a negative number (e.g., rather than indicating CO-45, providers should indicate CO 45).

ATTACHMENT 2
Explanation of Medical Benefits Form

(A copy of the "Explanation of Medical Benefits Form" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-01234 (11/14)

STATE OF WISCONSIN

FORWARDHEALTH
EXPLANATION OF MEDICAL BENEFITS

Instructions: Type or print clearly. If submitting a multiple page claim, include this form for each detail being billed. Refer to the Explanation of Medical Benefits Completion Instructions, F-01234A, for more information. Providers should submit one completed form per payer.

SECTION I — PAYER INFORMATION

1. ❑ Medicare ❑ Medicare Advantage ❑ Commercial Insurance_____

SECTION II — MEMBER INFORMATION

2. Name — Member (Last Name, First Name, Middle Initial)	3. Member ID / HICN	4. Relationship to Policyholder

SECTION III — PRIMARY POLICYHOLDER INFORMATION

5. Name — Primary Policyholder (Last Name, First Name, Middle Initial)	6. Primary Policy ID / HICN	7. Policy / Group Number

SECTION IV — HEADER ADJUDICATION INFORMATION

8. Date Payer Processed	11. Paid / Deny	13. Allowed	15. Coins PR 2	17. Noncovered CO 96	19. Blood Deduct PR 66	21. ANSI Reason Codes	
						ANSI Rsn Code	Amount
9. From Date of Service	12. Billed Amount	14. Paid	16. Deductible PR 1	18. Copay PR 3	20. Psych Reduct PR 122		
10. To Date of Service							

SECTION V — DETAIL ADJUDICATION INFORMATION

Detail No.	22. Date Payer Processed	25. Paid / Deny	27. Proc. Code	29. Allowed	31. Coins PR 2	33. Noncovered CO 96	35. Blood Deduct PR 66	37. ANSI Reason Codes	
								ANSI Rsn Code	Amount
	23. From Date of Service	26. Billed Amount	28. Revenue Code	30. Paid	32. Deductible PR 1	34. Copay PR 3	36. Psych Reduct PR 122		
	24. To Date of Service								
Detail No.	22.	25.	27.	29.	31.	33.	35.	37.	
	23.	26.	28.	30.	32.	34.	36.		
	24.								
Detail No.	22.	25.	27.	29.	31.	33.	35.	37.	
	23.	26.	28.	30.	32.	34.	36.		
	24.								
Detail No.	22.	25.	27.	29.	31.	33.	35.	37.	
	23.	26.	28.	30.	32.	34.	36.		
	24.								

(Continued)

Member ID

SECTION V — DETAIL ADJUDICATION INFORMATION (Continued)

Detail No.	22.	25.	27.	29.	31.	33.	35.	37.
	23.	26.	28.	30.	32.	34.	36.	
	24.							
Detail No.	22.	25.	27.	29.	31.	33.	35.	37.
	23.	26.	28.	30.	32.	34.	36.	
	24.							
Detail No.	22.	25.	27.	29.	31.	33.	35.	37.
	23.	26.	28.	30.	32.	34.	36.	
	24.							
Detail No.	22.	25.	27.	29.	31.	33.	35.	37.
	23.	26.	28.	30.	32.	34.	36.	
	24.							
Detail No.	22.	25.	27.	29.	31.	33.	35.	37.
	23.	26.	28.	30.	32.	34.	36.	
	24.							
Detail No.	22.	25.	27.	29.	31.	33.	35.	37.
	23.	26.	28.	30.	32.	34.	36.	
	24.							
Detail No.	22.	25.	27.	29.	31.	33.	35.	37.
	23.	26.	28.	30.	32.	34.	36.	
	24.							
Detail No.	22.	25.	27.	29.	31.	33.	35.	37.
	23.	26.	28.	30.	32.	34.	36.	
	24.							