Review of the Explanation of Medical Benefits Form, F-01234

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General Policy Information

Effective August 3, 2015, for professional and institutional paper claims and claims adjustments, the Explanation of Medical Benefits form must be included for each other payer indicated on the paper claim or claim adjustment regardless of the date of service or date of discharge.

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General Policy Information (Cont.)

The Explanation of Medical Benefits form requirement applies 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.

General Policy Information (Cont.)

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.

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General Policy Information (Cont.)

Submitting the Explanation of Medical Benefits form with paper claims and adjustments will ensure consistency with electronic claims and adjustments submitted via the ForwardHealth Portal or via the 837 Health Care Claim electronic transactions, including those submitted using Provider Electronic Solutions (PES) software, a clearinghouse, or a software vender.

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 form, F-13047 (08/15).
- 1500 and UB-04 claims and adjustments submitted that require special handling.
- Medicare crossover claims.

Revised Forms and Completion Instructions

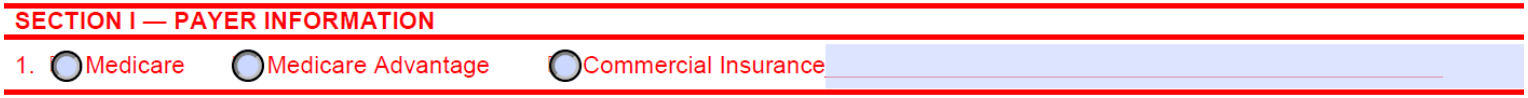
The following forms and completion instructions have been revised as a result of the Explanation of Medical Benefits form requirements:

- Adjustment/Reconsideration Request form, F-13046 (08/15).
- Timely Filling Appeals Request form, F-13047 (08/15).

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

In order for the 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 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 Online Handbook.

Section I — Payer Information



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.

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Section II — Member Information

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

- 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.

Section III — Primary Policyholder Information

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

- Element 5 — **Name — Primary Policy Holder** — 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 (Cont.)

Providers are required to complete Section IV of the Explanation of Medical Benefits form 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 of the Explanation of Medical Benefits form are left blank.

Note: Professional crossover claims require both the header and the detail information to process the claim.

Section IV — Header Adjudication Information

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							

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Section V — Detail Adjudication Information

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								

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 the section is left blank, providers are required to complete Section IV.

Note: Professional crossover claims require both the header and the detail information to process the claim.

Thank You