**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Health Care Access and Accountability

F-13046 (08/15)

**FORWARDHEALTH**

**ADJUSTMENT / RECONSIDERATION REQUEST**

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

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

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| **SECTION I — BILLING PROVIDER AND MEMBER INFORMATION** | | | | | | | | | | | | | |
| Indicate appropriate program.  BadgerCare Plus / SeniorCare / Wisconsin Medicaid  ADAP  WCDP  WWWP | | | | | | | | | | | | | |
| 1. Name — Billing Provider | | | | | | | | | | 2. Billing Provider’s Provider ID | | | |
| 3. Name — Member | | | | | | | | | | 4. Member Identification Number | | | |
| **SECTION II — CLAIM INFORMATION** | | | | | | | | | | | | | |
| 5. Remittance Advice (RA) or X12 835 Health Care Claim Payment / Advice (835) Report Date, Check Issue Date, or Payment Date | | | | | | | 6. Internal Control Number / Payer Claim Control Number | | | | | | |
| Add a new service line(s) to previously paid / allowed claim. (In Elements 7-15, enter information to be added.)  Correct detail on previously paid / allowed claim. (In Elements 7-12, enter information as it appears on the RA or 835.) | | | | | | | | | | | | | |
| 7. Date(s) of Service  From To | | 8. POS | 9. Procedure / NDC / Revenue Code | 10. Modifiers 1-4  Mod 1 Mod 2 Mod 3 Mod 4 | | | | | 11. Billed Amount | 12. Unit Quantity | 13. Family Planning Indicator | 14. EMG | 15. Rendering Provider Number |
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| **SECTION III — ADJUSTMENT INFORMATION** | | | | | | | | | | | | | |
| 16. Reason for Adjustment  Consultant review requested (include supporting documentation).  Recoup entire payment.  Other insurance — dental / pharmacy with OI-P $     .  Other insurance — professional / institutional (attach Explanation of Medical Benefits form, F-01234).  Copayment deducted in error.  Member in nursing home.  Covered days      .  Emergency.  Primary payer reconsideration.  Correct service line.  Other / comments. | | | | | | | | | | | | | |
| 17. **SIGNATURE —** Billing Provider | | | | | | | | | | 18. Date Signed | | | |
| 19. Claim Form Attached (Optional)  Yes  No | | | | | | | | | | | | | |