

**FORWARDHEALTH
 ADJUSTMENT / RECONSIDERATION REQUEST**

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

SECTION I — BILLING PROVIDER AND MEMBER INFORMATION

Indicate applicable program.

- BadgerCare Plus / SeniorCare / Wisconsin Medicaid WCDP WWWP

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

SECTION II — CLAIM INFORMATION

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

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

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

SECTION III — ADJUSTMENT INFORMATION

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

17. SIGNATURE — Billing Provider	18. Date Signed
---	-----------------

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

