

**WISCONSIN MEDICAID
 CLAIM REFUND**

Instructions: Type or print clearly.

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

1. Payee / Billing Provider's Medicaid Provider Number	2. Name — Payee / Billing Provider
3. Subscriber / Recipient Medicaid Identification Number	4. Name — Subscriber / Recipient

SECTION II — CLAIM INFORMATION

5. Payer Control Number / Internal Control Number		6. Check Issue Date / Report Date						
7. Date(s) of Service From	To	8. Procedure Code / National Drug Code / Revenue Code	9. Modifiers 1-4				10. Billed Amount	11. Refund Amount
			Mod 1	Mod 2	Mod 3	Mod 4		
							12. Refund Total	

SECTION III — REFUND INFORMATION

13. Reason for Refund (check one)
- Medicare paid.
 - Overpayment.
 - Other commercial health or dental insurance payment (OI-P) \$.
 - Not our patient.
 - Wrong date of service.
 - Duplicate payment by Wisconsin Medicaid.
 - Billing error.
 - Other / comments.

Mail this form and either the Medicaid-issued check or
 provider-issued refund check to

Wisconsin Medicaid
 Financial Services Cash Unit
 6406 Bridge Rd
 Madison WI 53784-0004

Maintain a copy of this form for your records.