FORWARDHEALTH
CLAIM REFUND COMPLETION INSTRUCTIONS

ForwardHealth requires the information indicated below to properly post a refund. Providers can submit either refunds or adjustment requests per payer control number (PCN) or internal control number (ICN), but should not do both. Adjustments must be submitted using the Adjustment/Reconsideration Request form, F-13046.

Members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid 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 applicants and members is confidential and is used for purposes directly related to program administration such as determining enrollment of the applicant, processing prior authorization requests, or processing provider claims for reimbursement.

Questions about refunds and other procedures or policies may be directed to Provider Services at (800) 947-9627. Mail this form to the applicable address listed on the Claim Refund, F-13066.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. Attach additional pages if more space is needed. Providers may photocopy the Claim Refund for their own use.

INSTRUCTIONS

Type or print clearly. Enter the following information from the provider's 835 Health Care Claim Payment/Advice (835) transaction or the Remittance Advice (RA).

SECTION I — BILLING PROVIDER AND MEMBER INFORMATION

Indicate the applicable program for which the refund is being submitted.

Element 1 — Payee / Billing Provider's Provider Number
Enter the payee or billing provider's eight-digit National Provider Identifier or Medicaid provider number to which the claim was paid.

Element 2 — Name — Payee / Billing Provider
Enter the payee or billing provider's name that corresponds to the provider number in Element 1.

Element 3 — Member Identification Number
Enter the member's 10-digit member ID.

Element 4 — Name — Member
Enter the complete name of the member for whom payment was received.

SECTION II — CLAIM INFORMATION

Element 5 — Payer Control Number / Internal Control Number
Enter the 15-digit PCN from the 835 transaction or ICN from the RA of the paid or allowed claim. (Use the claim number assigned to the most recently processed claim or adjustment.)

Element 6 — Check Issue Date / Report Date
Enter the check issue date from the 835 transaction or the date of the RA showing the paid claim that the provider is refunding.

Element 7 — Date(s) of Service
Enter the month, day, and year for each procedure in MM/DD/CCYY format.

Element 8 — Procedure Code / National Drug Code / Revenue Code
Enter the procedure code, National Drug Code, or revenue code for which the refund is being applied.

Element 9 — Modifiers 1-4
Enter the appropriate modifier(s).

Element 10 — Billed Amount
Enter the total billed amount for each line item.

Element 11 — Refund Amount
Enter the total refund amount for each line item.

Element 12 — Refund Total
Enter the total refund amount for the specific claim.

SECTION III — REFUND INFORMATION

Element 13 — Reason for Refund
Check the most appropriate box indicating the provider's reason for submitting the refund:

- *Medicare paid.*
- *Overpayment.*
- *Other commercial health or dental insurance payment.* Enter the amount paid by the other commercial health or dental insurance carrier.
- *Not our patient.*
- *Wrong date of service.*
- *Duplicate payment by ForwardHealth.*
- *Billing error.*
- *Other / Comments.* Add any clarifying information not previously included.

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