

WISCONSIN MEDICAID CLAIM REFUND COMPLETION INSTRUCTIONS

Wisconsin Medicaid 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, HCF 13046.

Recipients 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 eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) 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 or (608) 221-9883. Mail this form to the address on the Claim Refund form, HCF 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 form 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 and Status (R/S) Report.

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

Element 1 — Payee / Billing Provider's Medicaid Provider Number

Enter the payee or billing provider's eight-digit 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 — Subscriber / Recipient Medicaid Identification Number

Enter the subscriber's or recipient's 10-digit Medicaid identification number.

Element 4 — Name — Subscriber / Recipient

Enter the complete name of the subscriber or recipient for whom payment was received.

SECTION II — CLAIM INFORMATION

Element 5 — Payer Control Number / Internal Control Number (15 digits)

Enter the PCN from the 835 transaction or the ICN from the R/S Report 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 R/S Report showing the paid claim that the provider is refunding.

Element 7 — Date(s) of Service

Enter the month, day, and year for each procedure.

Element 8 — Procedure Code / National Drug Code / Revenue Code

Enter the procedure 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 Wisconsin Medicaid.*
- *Billing error.*
- *Other / comments.* Add any clarifying information not included above.

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