**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services

F-01159 (04/2017)

**FORWARDHEALTH**

**COMMERCIAL OTHER COVERAGE DISCREPANCY REPORT**

**Instructions:** Providers may use this form to notify ForwardHealth of discrepancies between other health care coverage information obtained through Wisconsin’s Enrollment Verification System and information received from another source. All three sections of this form must be completed. ForwardHealth will verify the information provided and update the member’s file (if applicable). Refer to the Commercial Other Coverage Discrepancy Report Completion Instructions, F-01159A, for more information. **Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly. Type or print clearly.**

Submit the completed form by fax to Coordination of Benefits at 608-221-4567 or by mail to the following address:

ForwardHealth

Coordination of Benefits

PO Box 6220

Madison WI 53716-6220

Allow five to seven business days for processing.

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| **SECTION I – PROVIDER AND MEMBER INFORMATION** | | |
| 1. Name – Provider | | 2. Provider ID / National Provider Identifier |
| 3. Name – Member (Last, First, Middle Initial) | | |
| 4. Date of Birth – Member | 5. Member ID | |
| **SECTION II – COMMERCIAL HEALTH INSURANCE AND MEDICARE SUPPLEMENTAL COVERAGE** | | |
| 6.  Add  Change  Delete | 7. Policy Type  Commercial  Medicare Supplemental  Long-Term Care (LTC) | |
| 8. Carrier Number | | |
| 9. Name – Insurance Company | | |
| 10. Address – Insurance Company (Street, City, State, ZIP Code) | | |
| 11. Name – Policyholder (Last, First, Middle Initial) | | |
| 12. Social Security Number – Policyholder | 13. Date of Birth – Policyholder | |
| 14. Gender – Policyholder  Male  Female  Unknown | 15. Relationship to Member – Policyholder  Self  Spouse  Child  Stepchild  Other | |
| 16. Group Number | 17. Policy Number | |

*Continued*

**COMMERCIAL OTHER COVERAGE DISCREPANCY REPORT** 2 of 2

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| **SECTION II – COMMERCIAL HEALTH INSURANCE AND MEDICARE SUPPLEMENTAL COVERAGE (Continued)** | | | |
| 18. Commercial or Medicare Supplemental Coverage Codes (Check all applicable options.)  Dental  Drug  Durable Medical Equipment (DME) Purchase  DME Rental  Home Health  Inpatient  Major Medical Physician  Nursing Home  Outpatient  Vision | | | |
| 19. LTC Coverage Only (Check only one option.)  LTC Only Cash  LTC Only Reimbursement | | | |
| 20. Coverage Start Date (Required) | 21. Open-Ended Coverage?  Yes  No | 22. Coverage End Date (Required if Open-Ended Coverage = No) | |
| **SECTION III – REPORT INFORMATION** | | |
| 23. Name – Individual Completing This Report | | 24. Date Report Completed |
| 25. Telephone Number / Extension | | |
| 26. Name – Source of Information Included on This Report | | 27. Telephone Number / Extension |
| 28. Comments | | |
| (Attach a copy of the applicable insurance card.) | | |