



Update
September 2008

No. 2008-178

Affected Program: Wisconsin Well Woman Program

To: All Providers

ForwardHealth Announces New Screening and Diagnostic Reporting Forms and Claims Submission Procedures for Wisconsin Well Woman Program Services (UB-04)

This *ForwardHealth Update* announces the following new screening and diagnostic reporting forms, required with the implementation of ForwardHealth interChange, for Wisconsin Well Woman Program (WWWP) services:

- Breast and Cervical Cancer Screening Activity Report (ARF), F-44723 (10/08).
- Breast Cancer Diagnostic and Follow-Up Report (DRF), F-44724 (10/08).
- Cervical Cancer Diagnostic and Follow-Up Report (DRF), F-44729 (10/08).

This *Update* also announces new electronic claim submission procedures and revised paper claim form instructions for WWWP institutional services with the implementation of the interChange system and the adoption of National Provider Identifiers. Sample UB-04 claim forms are included in this *Update*.

Information in this *Update* applies to providers who render services for WWWP members.

Implementation of ForwardHealth interChange

In November 2008, the Department of Health Services (DHS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS). ForwardHealth interChange will be supported as part of

the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization requests through the secure ForwardHealth Portal. Refer to the March 2008 *ForwardHealth Update* (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

With the implementation of the ForwardHealth interChange system, important changes will be made to the following for the Wisconsin Well Woman Program (WWWP):

- Revised screening and diagnostic reporting forms.
- Revised paper claim form completion instructions.
- Electronic claims submission procedures.

Changes indicated in this *Update* are not policy or coverage related.

New Reporting Forms

With the implementation of interChange, the WWWP has created new screening and diagnostic reporting forms. The WWWP requires providers to submit the following forms to report screening and diagnostic procedures for WWWP members:

- Breast and Cervical Cancer Screening Activity Report (ARF), F-44723 (10/08).
- Breast Cancer Diagnostic and Follow-Up Report (DRF), F-44724 (10/08).
- Cervical Cancer Diagnostic and Follow-Up Report (DRF), F-44729 (10/08).

Refer to Attachments 1-6 of this *Update* for copies of the forms and completion instructions. Providers may photocopy the forms and completion instructions included in this *Update*.

Submitting Forms

Screening and diagnostic reporting forms should continue to be submitted on paper to the following address:

WWWP
PO Box 6645
Madison WI 53716-0645

ForwardHealth will accept new WWWP screening and diagnostic reporting forms beginning at 8 a.m. on Monday, November 10, 2008. Older versions of WWWP screening and diagnostic reporting forms must be received by 4 p.m. on Wednesday, November 5, 2008. Older versions of these forms received after this date will be returned to the provider unprocessed.

Refer to Attachment 7 for a calendar of important dates for submitting forms.

UB-04 Claim Form Changes

Following the implementation of ForwardHealth interChange, providers will be required to use the UB-04 Claim Form with the instructions included in this *Update*. Claims received on the UB-92 Claim Form after

implementation will be returned to the provider unprocessed.

Refer to the September 2008 *Update* (2008-184), titled “New Effective Dates for ForwardHealth Implementation,” for more information about effective dates for claim submissions.

Refer to Attachments 8 and 9 for completion instructions and a sample UB-04 Claim Form for WWWP services. Attachment 10 is a sample of an incorrectly completed claim form.

Note: Providers should only use these instructions for claims received following ForwardHealth interChange implementation. Following these procedures prior to implementation will result in the claim being denied.

Revenue Codes on UB-04 Claims

Providers are reminded that they are required to indicate a four-digit revenue code on UB-04 claims requiring a revenue code. Claims that have invalid revenue codes will be denied.

Entering Dates on UB-04 Claims

Providers should enter the “from” DOS in Form Locator 45 using the MMDDYY format and enter the “to” DOS in Form Locator 49 using the DD format. Providers should no longer enter dates in Form Locator 43.

Valid Diagnosis Codes Required

Providers are reminded that claims submitted on the UB-04 Claim Form will be monitored for the most specific *International Classification of Disease, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available will be denied.

Detail Quantity

Providers are required to enter a quantity in Form Locator 46. ForwardHealth will not assume a quantity of one if Form Locator 46 is left blank. If the detail quantity is missing in Form Locator 46 on UB-04 claims, the detail will deny.

Electronic Claim Submission

Beginning with the implementation of interChange, WWWP providers will have the option to submit claims electronically. Submitting claims electronically:

- Improves cash flow.
- Offers efficient and timely payments.
- Reduces billing and processing errors.
- Reduces clerical effort.

Providers may use any of the following methods to submit electronic claims after the implementation of ForwardHealth interChange:

- Online claim submission through the ForwardHealth Portal.
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant claim transaction submissions through Electronic Data Interchange (EDI).
- Provider Electronic Solutions (PES) software.

Claims submitted electronically will be pending for 60 days in ForwardHealth interChange until they can be matched up with the appropriate screening and diagnostic reporting form submitted on paper. Wisconsin Well Woman Program providers are not required to submit additional documentation (e.g., an attachment cover sheet) with the screening and diagnostic reporting forms.

Claims on the Portal

The Portal will offer providers a more convenient way to track the status of submitted claims, submit individual claims, correct errors on claims, and determine what claims are in “pay” status. Providers will have the ability to search for and view the status of all of their finalized

claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers will be able to correct it on the Portal and resubmit it to ForwardHealth.

Refer to the July 2008 *Update* (2008-94), titled “Introducing the ForwardHealth Portal,” for more information about the features of the Portal and the September 2008 *Update* (2008-167), titled “Claims and Adjustments Using the ForwardHealth Portal,” for more information about submitting claims on the Portal.

HIPAA-Compliant Claim and Remittance Transactions

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A “trading partner” is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth.
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider.

Wisconsin Well Woman Program providers should refer to the ForwardHealth companion documents for more information about electronic transactions. Companion documents provide software firms, billing services and clearinghouses, and computer processing staff who manage the technical component (e.g., telecommunication, exchange file creation, translation) of electronic transactions with useful technical information about ForwardHealth’s standards for HIPAA-compliant transactions. Companion documents include information to help trading partners to successfully exchange HIPAA-compliant electronic transactions with ForwardHealth.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. Using PES software, providers may

submit HIPAA-compliant electronic claims and adjustments to ForwardHealth. The PES software cannot be used to submit claims to Medicare or commercial health insurance payers.

Provider Electronic Solutions software is available to all providers free of charge and available to download from the Portal at www.forwardhealth.wi.gov/. Providers may call the EDI Helpdesk at (866) 416-4979 with questions about PES.

National Provider Identifiers

With the implementation of interChange, health care providers will be required to use National Provider Identifiers (NPIs) when conducting business with ForwardHealth. This will include indicating an NPI and related data, as applicable, on all provider fields on paper and electronic claims. Refer to the August 2008 *Update* (2008-148), titled “National Provider Identifier Requirements with the Implementation of ForwardHealth interChange,” for more information about NPIs.

Adjustment/Reconsideration Request Changes

Providers will be required to use the revised Adjustment/Reconsideration Request, F-13046 (10/08). The Adjustment/Reconsideration Request was revised to be able to be used by all ForwardHealth providers to request an adjustment of an allowed claim (a paid or partially paid claim). An adjustment or reconsideration request received in any other format will be returned to the provider unprocessed.

Refer to Attachments 11 and 12 for the revised Adjustment/Reconsideration Request Completion Instructions, F-13046A (10/08), and the Adjustment/Reconsideration Request.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at dhs.wisconsin.gov/forwardhealth/.

P-1250

ATTACHMENT 1

Breast and Cervical Cancer Screening Activity Report (ARF) Completion Instructions

(A copy of the “Breast and Cervical Cancer Screening Activity Report [ARF] Completion Instructions” is located on the following pages.)

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**WISCONSIN WELL WOMAN PROGRAM (WWWP)
BREAST AND CERVICAL CANCER SCREENING ACTIVITY REPORT (ARF)
COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, and address.

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the service.

The use of this form is mandatory when submitting claims for Wisconsin Well Woman Program services.

For reimbursement, mail this form with the completed claim to the following address:

Wisconsin Well Woman Program
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

SECTION I — BILLING PROVIDER INFORMATION

Element 1 — Provider ID

Required. ForwardHealth providers are required to enter a National Provider Identifier (NPI). Non-healthcare providers are required to enter their Provider ID.

Element 2 — Name — Billing Provider

Enter the billing provider's name.

Element 3 — Taxonomy Code

Required. Enter the taxonomy code assigned by ForwardHealth.

Element 4 — Practice Location ZIP+4 Code

Required. Enter the complete ZIP+4 code associated with the practice service location on file with ForwardHealth.

SECTION II — MEMBER PERSONAL INFORMATION

Element 5 — Last Name — Member

Required. Enter the member's last name.

Element 6 — First Name — Member

Required. Enter the member's first name.

Element 7 — Middle Initial — Member

Not required. Enter the member's middle initial.

Element 8 — Previous Last Name — Member

Not required. Enter the member's previous last name, if applicable.

Element 9 — Member Identification Number

Required. Enter the member ID.

Element 10 — Date of Birth — Member

Required. Enter the member's date of birth in MM/DD/CCYY format.

SECTION III — BREAST AND CERVICAL SCREENING

BREAST SCREENING HISTORY

Element 11 — Previous Mammogram?

Select either “Yes,” “No,” or “Unknown” to reflect whether or not the member has had a previous mammogram.

Element 12 — Date of Previous Mammogram

If known, provide the date (in MM/DD/CCYY format) on which the member received her most recent mammogram.

Element 13 — Member Reports Breast Symptoms?

Check “Yes,” “No,” or “Unknown” regarding whether or not the member has reported breast symptoms.

CLINICAL BREAST EXAM

Element 14 — Purpose of CBE

Check whether the member’s clinical breast exam (CBE) is a screening or repeat exam.

Element 15 — Date of CBE

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received the CBE.

Element 16 — Name — Rendering Provider

Enter the rendering provider’s name.

Element 17 — RESULT

Required if this procedure is performed. Check one box to reflect the results of the CBE. If a shaded result is selected, follow up is required.

MAMMOGRAM

Element 18 — Indication for Initial Mammogram

Check the appropriate box to indicate reason for initial mammogram.

Element 19 — Breast Diagnostic Referral Date

Enter the date (in MM/DD/CCYY format) on which the member received the breast diagnostic referral.

Element 20 — Date of Initial Mammogram

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an initial mammogram.

Element 21 — Name — Rendering Provider

Enter the rendering provider’s name.

Element 22 — RESULT

Required if this procedure is performed. Check one box to reflect the results of the mammogram. If a shaded result is selected, follow up is required.

CERVICAL SCREENING HISTORY

Element 23 — Prior Pap Test?

Select either “Yes,” or “No” to reflect whether or not the member has had a prior pap test.

Element 24 — Date of Last Pap Test

If Element 23 is marked “Yes,” enter the date (in MM/DD/CCYY format) on which the member received her last pap test.

PELVIC EXAM

Element 25 — Date of Pelvic Exam

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a pelvic exam.

Element 26 — Name — Rendering Provider

Enter the rendering provider’s name.

Element 27 — RESULT

Required if this procedure is performed. Check one box to reflect the results of the pelvic exam. If shaded result is selected, follow up is required.

PAP TEST

Element 28 — Indication for Pap Test

Check appropriate box to indicate reason for pap test.

Element 29 — Date of Cervical Diagnostic Referral

Enter the date (in MM/DD/CCYY format) on which the member received a cervical diagnostic referral.

Element 30 — Type of Pap Test

Select whether the pap test is liquid based or conventional.

Element 31— Date of Pap Test

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a pap test.

Element 32 — Name — Rendering Provider

Enter the rendering provider's name.

Element 33 — ADEQUACY OF PAP TEST SPECIMEN

Required. Check one box to signify whether the pap test specimen is satisfactory or unsatisfactory.

Element 34 — RESULT

Required if this procedure is performed. Check one box only. If a shaded result is selected, follow up is required.

HPV TEST

The WWWP reimburses a Human Papilloma Virus (HPV) test only as an immediate follow-up to Pap Test results of ASC-US; one year to follow up to LSIL.

Element 35 — Date of HPV Test

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an HPV test.

Element 36 — Result

Required if this procedure is performed. Select the result of the member's HPV test.

BREAST FOLLOW-UP RECOMMENDATION

Element 37 — Recommendation(s)

This element is required when CBE or Mammogram sections are completed. Check all applicable boxes. Include the number of months for "Follow Routine Screening" and "Short-Term Follow up."

CERVICAL FOLLOW-UP RECOMMENDATION

Element 38 — Recommendation(s)

This element is required when the Pelvic Exam, Pap Test, or HPV Test sections are completed. Check all applicable boxes. Include the number of months for "Follow Routine Screening" and "Short-Term Follow up."

Element 39 — NOTES

Include notes, as appropriate.

ATTACHMENT 2

Breast and Cervical Cancer Screening Activity Report (ARF)

(A copy of the “Breast and Cervical Cancer Screening Activity Report [ARF]” is located on the following pages.)

**WISCONSIN WELL WOMAN PROGRAM
 BREAST AND CERVICAL CANCER SCREENING ACTIVITY REPORT (ARF)**

Instructions: Before completing this form, refer to the Breast and Cervical Cancer Screening Activity Report Completion Instructions, F-44723A. For reimbursement, mail the claim and this completed form to Wisconsin Well Woman Program (WWWP), P.O. Box 6645, Madison, WI 53716-0645.

SECTION I — BILLING PROVIDER INFORMATION

1. Provider ID	2. Name — Billing Provider	3. Taxonomy Code	4. Practice Location ZIP+4 Code
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SECTION II — MEMBER PERSONAL INFORMATION

5. Last Name — Member	6. First Name — Member	7. Middle Initial — Member
8. Previous Last Name — Member	9. Member Identification Number	10. Date of Birth — Member (MM/DD/CCYY)

SECTION III — BREAST AND CERVICAL SCREENING

BREAST SCREENING HISTORY	CERVICAL SCREENING HISTORY
11. Previous Mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23. Prior Pap Test? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Date of Previous Mammogram (MM/DD/CCYY)	24. Date of Last Pap Test (MM/DD/CCYY)
13. Member Reports Breast Symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	PELVIC EXAM
CLINICAL BREAST EXAM	25. Date of Pelvic Exam (MM/DD/CCYY)
14. Purpose of CBE (Check One Box Only) <input type="checkbox"/> Screening <input type="checkbox"/> Repeat	26. Name — Rendering Provider (Print)
15. Date of CBE (MM/DD/CCYY)	27. RESULT (Check One Box Only) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal — Not Suspicious for Cervical Cancer <input type="checkbox"/> Abnormal — Suspicious for Cervical Cancer Shading indicates additional procedures needed to complete cervical cycle.
16. Name — Rendering Provider (Print)	
17. RESULT (Check One Box Only) <input type="checkbox"/> Normal Exam <input type="checkbox"/> Discrete Palpable Mass — Suspicious for Cancer <input type="checkbox"/> Benign Finding <input type="checkbox"/> Nipple or Areolar Scaliness <input type="checkbox"/> Discrete Palpable Mass — Dx Benign <input type="checkbox"/> Skin Dimpling or Retraction <input type="checkbox"/> Bloody or Serous Nipple Discharge Shading indicates additional procedures needed to complete breast cycle.	PAP TEST
MAMMOGRAM	28. Indication for Pap Test <input type="checkbox"/> Routine Pap Test <input type="checkbox"/> Patient under surveillance for a previous abnormal test. <input type="checkbox"/> Pap test done by a non-program funded provider, patient referred in for diagnostic evaluation. <input type="checkbox"/> Pap test not done. Patient proceeded directly for diagnostic work-up or HPV test.
18. Indication for Initial Mammogram <input type="checkbox"/> Routine Screening Mammogram <input type="checkbox"/> Initial mammogram performed to evaluate symptoms, positive CBE result, or previous abnormal mammogram result. <input type="checkbox"/> Initial mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation. <input type="checkbox"/> Initial mammogram not done. Patient only received CBE, or proceeded directly for other imaging or diagnostic work-up (use Breast Cancer Diagnostic and Follow-Up Report [DRF], F-44724).	29. Date of Cervical Diagnostic Referral (MM/DD/CCYY)
19. Date of Breast Diagnostic Referral (MM/DD/CCYY)	30. Type of Pap Test (Check One Box Only) <input type="checkbox"/> Liquid based** <input type="checkbox"/> Conventional ** Reimbursed at rate of Conventional Pap Smear.
20. Date of Initial Mammogram (MM/DD/CCYY)	31. Date of Pap Test (MM/DD/CCYY)
21. Name — Rendering Provider (Print)	32. Name — Rendering Provider (Print)
22. RESULT (Check One Box Only) <input type="checkbox"/> Negative (BI-RADS 1) <input type="checkbox"/> Benign Findings (BI-RADS 2) <input type="checkbox"/> Probably Benign — Short-Term Follow up (BI-RADS 3) <input type="checkbox"/> Suspicious Abnormality — Consider Biopsy (BI-RADS 4) <input type="checkbox"/> Highly Suggestive of Malignancy (BI-RADS 5) <input type="checkbox"/> Assessment Incomplete (Findings Require Additional Evaluation) (BI-RADS 0) <input type="checkbox"/> Film Comparison Required (BI-RADS 0) <input type="checkbox"/> Unsatisfactory Shading indicates additional procedures needed to complete breast cycle.	33. ADEQUACY OF PAP SMEAR SPECIMEN (Check One Box Only) <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory
	34. RESULT (Check One Box Only) <input type="checkbox"/> AGC (Abnormal Glandular Cells Including Adenocarcinomas) <input type="checkbox"/> ASC-H (Atypical Squamous Cells [ASC-US Cannot Exclude HSIL]) <input type="checkbox"/> ASC-US (Atypical Squamous Cells Undetermined Significance) <input type="checkbox"/> High-Grade SIL (HSIL): Moderate and Severe Dysplasia, CIS / CIN 2 / CIN 3 <input type="checkbox"/> Low-Grade SIL Including HPV Changes (LSIL: HPV, Mild Dysplasia, CIN I) <input type="checkbox"/> Negative <input type="checkbox"/> Squamous Cell Carcinoma Shading indicates additional procedures needed to complete cervical cycle.

Continued



SECTION III — BREAST AND CERVICAL SCREENING (Continued)			
HPV TEST	CERVICAL FOLLOW-UP RECOMMENDATION		
<p>The WWWP covers HPV test only as an immediate follow-up to Pap Test results of ASC-US; one year to follow up to LSIL.</p>	<p>38. Recommendations(s)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Follow Routine Screening _____ Months <input type="checkbox"/> Short-Term Follow up _____ Months <input type="checkbox"/> HPV Test <input type="checkbox"/> Colposcopy with Biopsy <input type="checkbox"/> Colposcopy Without Biopsy </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> ECC Alone <input type="checkbox"/> Diagnostic LEEP <input type="checkbox"/> Diagnostic Cone <input type="checkbox"/> Endometrial Biopsy** <input type="checkbox"/> Hysterectomy* <p>* Not covered by WWWP. ** Only covered if Pap result is AGC.</p> </td> </tr> </table>	<input type="checkbox"/> Follow Routine Screening _____ Months <input type="checkbox"/> Short-Term Follow up _____ Months <input type="checkbox"/> HPV Test <input type="checkbox"/> Colposcopy with Biopsy <input type="checkbox"/> Colposcopy Without Biopsy	<input type="checkbox"/> ECC Alone <input type="checkbox"/> Diagnostic LEEP <input type="checkbox"/> Diagnostic Cone <input type="checkbox"/> Endometrial Biopsy** <input type="checkbox"/> Hysterectomy* <p>* Not covered by WWWP. ** Only covered if Pap result is AGC.</p>
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<p>35. Date of HPV Test (MM/DD/CCYY)</p>			
<p>36. Result (Check One Box Only) <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p>			
BREAST FOLLOW-UP RECOMMENDATION			
<p>37. Recommendation(s)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Follow Routine Screening _____ Months <input type="checkbox"/> Short-Term Follow up _____ Months <input type="checkbox"/> Film Comparison to Evaluate an Assessment Incomplete Mammogram <input type="checkbox"/> Additional Mammographic Views <input type="checkbox"/> Ultrasound <input type="checkbox"/> Breast Consultation <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Biopsy </td> <td style="width: 50%;"></td> </tr> </table>		<input type="checkbox"/> Follow Routine Screening _____ Months <input type="checkbox"/> Short-Term Follow up _____ Months <input type="checkbox"/> Film Comparison to Evaluate an Assessment Incomplete Mammogram <input type="checkbox"/> Additional Mammographic Views <input type="checkbox"/> Ultrasound <input type="checkbox"/> Breast Consultation <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Biopsy	
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<p>39. Notes</p>			

ATTACHMENT 3

Breast Cancer Diagnostic and Follow Up Report (DRF) Completion Instructions

(A copy of the “Breast Cancer Diagnostic and Follow Up Report [DRF] Completion Instructions” is located on the following pages.)

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**WISCONSIN WELL WOMAN PROGRAM
BREAST CANCER DIAGNOSTIC AND FOLLOW UP REPORT (DRF)
COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when submitting claims for ForwardHealth.

For reimbursement, mail this form with the completed claim to the following address:

Wisconsin Well Woman Program
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

SECTION I — BILLING PROVIDER INFORMATION

Element 1 — Provider ID

Required. ForwardHealth providers are required to enter a National Provider Identifier (NPI). Non-healthcare providers are required to enter their Provider ID.

Element 2 — Name — Billing Provider

Required. Enter the billing provider's name.

Element 3 — Taxonomy Code

Required. Enter the taxonomy code assigned by ForwardHealth.

Element 4 — Practice Location ZIP+4 Code

Required. Enter the complete ZIP+4 code associated with the practice service location on file with ForwardHealth.

SECTION II — MEMBER PERSONAL INFORMATION

Element 5 — Last Name — Member

Required. Enter the member's last name.

Element 6 — First Name — Member

Required. Enter the member's first name.

Element 7 — Middle Initial — Member

Enter the member's middle initial.

Element 8 — Previous Last Name — Member

Enter the member's previous last name, if applicable.

Element 9 — Member Identification Number

Required. Enter the member ID.

Element 10 — Date of Birth

Required. Enter the member's date of birth in MM/DD/CCYY format.

SECTION III — BREAST DIAGNOSTIC PROCEDURES

ADDITIONAL MAMMOGRAPHIC VIEWS

Element 11 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a mammogram.

Element 12 — Name — Rendering Provider

Enter the name of the rendering provider.

Element 13 — RESULT

Required if this procedure is performed. Check one box only to reflect results of mammogram. If shaded result is selected, follow up is required.

BREAST CONSULTATION

Element 14 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a breast consultation.

Element 15 — Name — Rendering Provider

Enter the name of the rendering provider.

Element 16 — RESULT / RECOMMENDATION

Required if this procedure is performed. Check one box only to reflect the results of the breast consultation. If shaded result is selected, follow up is required.

BIOPSY

Element 17 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a biopsy.

Element 18 — Name — Rendering Provider

Enter the rendering provider's name.

Element 19 — Biopsy Associated Imaging

Select either "mammogram" or "ultrasound," if applicable.

Element 20 — RESULT

Required if this procedure is performed. Check one box only to reflect results of biopsy. If shaded result is selected, follow up is required.

FILM COMPARISON

Element 21 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a film comparison.

Element 22 — Name — Rendering Provider

Enter the rendering provider's name.

Element 23 — RESULT

Required if this procedure is performed. Check one box only to reflect the results of the film comparison. If shaded result is selected, follow up is required.

FINE NEEDLE ASPIRATION

Element 24 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a fine needle aspiration.

Element 25 — Name — Rendering Provider

Enter the rendering provider's name.

Element 26 — RESULT

Required if this procedure is performed. Check one box only to reflect the results of the fine needle aspiration. If shaded result is selected, follow up is required.

ULTRASOUND

Element 27 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an ultrasound.

Element 28 — Name — Rendering Provider

Enter the rendering provider's name.

Element 29 — RESULT

Required if this procedure is performed. Check one box only to reflect the results of the ultrasound. If shaded result is selected, follow up is required.

Element 30 — NOTES

Enter notes, if applicable.

Element 31 — RECOMMENDATION

This field is required if elements from Additional Mammographic Views, Breast Consultation, Biopsy, Film Comparison, Fine Needle Aspiration, or Ultrasound are completed. Check all applicable boxes.

Element 32 — STATUS OF FINAL DIAGNOSIS

Required. Select one box only to reflect the status of the member's final diagnosis.

Element 33 — FINAL DIAGNOSIS

If "complete" is checked in Element 32, this field is required. Select one box only to reflect the final diagnosis and enter the date in MM/DD/CCYY format.

Element 34 — TUMOR STAGE AND TUMOR SIZE

Check one box to reflect the stage of the member's tumor, if applicable. Enter the size of the member's tumor in centimeters.

Element 35 — TREATMENT STATUS

Check one box only to reflect the member's treatment status.

Element 36 — TREATMENT DATE

Enter date (in MM/DD/CCYY format) as applicable.

ATTACHMENT 4

Breast Cancer Diagnostic and Follow-Up Report (DRF)

(A copy of the “Breast Cancer Diagnostic and Follow-Up Report [DRF]” is located on the following pages.)

**WISCONSIN WELL WOMAN PROGRAM
 BREAST CANCER DIAGNOSTIC AND FOLLOW-UP REPORT (DRF)**

Instructions: Before completing this form, refer to the Breast Cancer Diagnostic and Follow-Up Report (DRF) Completion Instructions, F-44724A. For reimbursement, send the claim and this completed form to Wisconsin Well Woman Program (WWWP), P.O. Box 6645, Madison, WI 53716-0645.

SECTION I — BILLING PROVIDER INFORMATION

1. Provider ID	2. Name — Billing Provider	3. Taxonomy Code	4. Practice Location ZIP+4 Code
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SECTION II — MEMBER PERSONAL INFORMATION

5. Last Name — Member	6. First Name — Member	7. Middle Initial — Member
8. Previous Last Name — Member	9. Member Identification Number	10. Date of Birth (MM/DD/CCYY)

SECTION III — BREAST DIAGNOSTIC PROCEDURES

ADDITIONAL MAMMOGRAPHIC VIEWS	FILM COMPARISON
11. Date Performed (MM/DD/CCYY)	21. Date Performed (MM/DD/CCYY)
12. Name — Rendering Provider (Print)	22. Name — Rendering Provider (Print)
13. RESULT (Check One Box Only) <input type="checkbox"/> Negative (BI-RADS 1) <input type="checkbox"/> Benign Findings (BI-RADS 2) <input type="checkbox"/> Probably Benign — Short-Term Follow up (BI-RADS 3) <input type="checkbox"/> Suspicious Abnormality — Consider Biopsy (BI-RADS 4) <input type="checkbox"/> Highly Suggestive of Malignancy (BI-RADS 5) <input type="checkbox"/> Assessment Incomplete (Findings Require Additional Evaluation) (BI-RADS 0)	23. RESULT (Check One Box Only) <input type="checkbox"/> Negative (BI-RADS 1) <input type="checkbox"/> Benign Findings (BI-RADS 2) <input type="checkbox"/> Probably Benign — Short-Term Follow up (BI-RADS 3) <input type="checkbox"/> Suspicious Abnormality — Consider Biopsy (BI-RADS 4) <input type="checkbox"/> Highly Suggestive of Malignancy (BI-RADS 5) <input type="checkbox"/> Assessment Incomplete (Findings Require Additional Evaluation) (BI-RADS 0)
BREAST CONSULTATION	FINE NEEDLE ASPIRATION
14. Date Performed (MM/DD/CCYY)	24. Date Performed (MM/DD/CCYY)
15. Name — Rendering Provider (Print)	25. Name — Rendering Provider (Print)
16. RESULT / RECOMMENDATION (Check One Box Only) <input type="checkbox"/> No Intervention, Routine Follow up <input type="checkbox"/> Short-Term Follow up <input type="checkbox"/> Biopsy / FNA Recommended	26. RESULT (Check One Box Only) <input type="checkbox"/> Not Suspicious for Cancer <input type="checkbox"/> Suspicious for Cancer <input type="checkbox"/> No Fluid or Tissue Obtained
BIOPSY	ULTRASOUND
17. Date Performed (MM/DD/CCYY)	27. Date Performed (MM/DD/CCYY)
18. Name — Rendering Provider (Print)	28. Name — Rendering Provider (Print)
19. Biopsy Associated Imaging <input type="checkbox"/> Mammogram <input type="checkbox"/> Ultrasound	29. RESULT (Check One Box Only) <input type="checkbox"/> Negative (BI-RADS 1) <input type="checkbox"/> Benign Findings (BI-RADS 2) <input type="checkbox"/> Probably Benign — Short-Term Follow up (BI-RADS 3) <input type="checkbox"/> Suspicious Abnormality — Consider Biopsy (BI-RADS 4) <input type="checkbox"/> Highly Suggestive of Malignancy (BI-RADS 5) <input type="checkbox"/> Assessment Incomplete (Findings Require Additional Evaluation) (BI-RADS 0)
20. RESULT (Check One Box Only) <input type="checkbox"/> Normal Breast Tissue <input type="checkbox"/> Other Benign Changes <input type="checkbox"/> Atypical Hyperplasia *Treatment Required <input type="checkbox"/> Ductal Carcinoma in Situ (DCIS)* <input type="checkbox"/> Lobular Carcinoma in Situ (LCIS) <input type="checkbox"/> Invasive Breast Cancer*	

Shading indicates additional follow up required for WWWP.

30. NOTES

31. RECOMMENDATION

- Follow Routine Screening Schedule _____ Months
 Additional Mammographic Views Ultrasound
 Treatment
 Short-Term Follow up _____ Months
 Breast Consultation Fine Needle Aspiration Biopsy

32. STATUS OF FINAL DIAGNOSIS — Check One Box Only

- Complete* Pending Member Deceased Lost to Follow up Refused Work-up

*Must complete Element 33 (Final Diagnosis).

33. FINAL DIAGNOSIS (Required if "Complete" is checked in Element 32 [Status of Final Diagnosis].)

- Date (MM/DD/CCYY) if any box below is checked. _____
 Breast Cancer Not Diagnosed Lobular Carcinoma in Situ (LCIS) Ductal Carcinoma in Situ (DCIS)* Invasive Breast Cancer**

*Complete Treatment Date and Treatment Status.

**Complete Treatment Date, Treatment Status, Tumor Stage, and Tumor Size.

Continued



ATTACHMENT 5

Cervical Cancer Diagnostic and Follow Up Report (DRF) Completion Instructions

(A copy of the “Cervical Cancer Diagnostic and Follow Up Report [DRF] Completion Instructions” is located on the following pages.)

(This page was intentionally left blank.)

WISCONSIN WELL WOMAN PROGRAM CERVICAL CANCER DIAGNOSTIC AND FOLLOW UP REPORT (DRF) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when submitting claims for Wisconsin Well Woman Program services.

For reimbursement, mail this completed form with the completed claim to the following address:

Wisconsin Well Woman Program
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

SECTION I – BILLING PROVIDER INFORMATION

Element 1 — Provider ID

Required. ForwardHealth providers are required to enter a National Provider Identifier (NPI). Non-healthcare providers are required to enter their Provider ID.

Element 2 — Name — Billing Provider

Required. Enter the provider's name.

Element 3 — Taxonomy Code

Required. Enter the taxonomy code assigned by ForwardHealth.

Element 4 — Practice Location ZIP+4 Code

Required. Enter the complete ZIP+4 code associated with the practice service location on file with ForwardHealth.

SECTION II — MEMBER PERSONAL INFORMATION

Element 5 — Last Name — Member

Required. Enter the member's last name.

Element 6 — First Name — Member

Required. Enter the member's first name.

Element 7 — Middle Initial — Member

Enter the member's middle initial.

Element 8 — Previous Last Name — Member

Enter the member's previous last name, if applicable.

Element 9 — Member Identification Number

Required. Enter the member ID.

Element 10 — Date of Birth

Required. Enter the member's date of birth in MM/DD/CCYY format.

SECTION III — CERVICAL DIAGNOSTIC PROCEDURES

COLPOSCOPY WITH BIOPSY / ENDOCERVICAL CURETTAGE

Element 11 — Procedure Performed

Check the appropriate box indicating whether a colposcopy with biopsy or an endocervical curettage procedure is performed.

Element 12 — Date Performed

Required if one of these procedures is performed. Enter the date (in MM/DD/CCYY format) on which the member received a colposcopy with biopsy or an endocervical curettage.

Element 13 — Name — Rendering Provider

Enter the rendering provider's name.

Element 14 — RESULT

Required if one of these procedures is performed. Select one box only to reflect the result of the member's colposcopy with biopsy or endocervical curettage. If a shaded result is selected, follow up is required.

LOOP ELECTROSURGICAL EXCISION PROCEDURE (LEEP)

Element 15 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a loop electrosurgical excision procedure (LEEP).

Element 16 — Name — Rendering Provider

Enter the rendering provider's name.

Element 17 — RESULT

Required if this procedure is performed. Select one box only to reflect the result of the member's LEEP. If a shaded result is selected, follow up is required.

ENDOMETRIAL BIOPSY

Element 18 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received an endometrial biopsy.

Element 19 — Name — Rendering Provider

Enter the rendering provider's name.

Element 20 — RESULT

Required if this procedure is performed. Select one box only to reflect the result of the member's endometrial biopsy. If a shaded result is selected, follow up is required.

COLPOSCOPY WITHOUT BIOPSY

Element 21 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a colposcopy without biopsy.

Element 22 — Name — Rendering Provider

Enter the rendering provider's name.

Element 23 — RESULT

Required if this procedure is performed. Select one box only to reflect the result of the member's colposcopy without biopsy. If a shaded result is selected, follow up is required.

COLD KNIFE CONE

Element 24 — Date Performed

Required if this procedure is performed. Enter the date (in MM/DD/CCYY format) on which the member received a cold knife cone.

Element 25 — Name — Rendering Provider

Enter the rendering provider's name.

Element 26 — RESULT

Required if this procedure is performed. Select one box only to reflect the result of the member's cold knife cone. If a shaded result is selected, follow up is required.

Element 27 — NOTES

Enter notes, if applicable.

Element 28 — RECOMMENDATION

This element is required if elements under Colposcopy with Biopsy/Endocervical Curettage, Loop Electrosurgical Excision Procedure (LEEP), Endometrial Biopsy, Colposcopy Without Biopsy, and/or Cold Knife Cone are completed. Check all applicable recommendations.

Element 29 — STATUS OF FINAL DIAGNOSIS

Required. Check one box only to reflect the status of the member's final diagnosis.

Element 30 — FINAL DIAGNOSIS

If "Complete" is selected in Element 29, this element is required. Select one box only to reflect the final diagnosis. Enter date in MM/DD/CCYY format.

Element 31 — TUMOR STAGE

Check one box to reflect the member's tumor stage.

Element 32 — TREATMENT STATUS

Check one box only to reflect the member's treatment status.

Element 33 — TREATMENT DATE

Enter date in MM/DD/CCYY format, as applicable.

ATTACHMENT 6

Cervical Cancer Diagnostic and Follow-Up Report (DRF)

(A copy of the “Cervical Cancer Diagnostic and Follow-Up Report [DRF]” is located on the following pages.)

**WISCONSIN WELL WOMAN PROGRAM
 CERVICAL CANCER DIAGNOSTIC AND FOLLOW-UP REPORT (DRF)**

Instructions: Before completing this form, refer to the Cervical Cancer Diagnostic and Follow-Up Report (DRF), F-44729A. For reimbursement, send claim plus this completed form to Wisconsin Well Woman Program (WWWP), P.O. Box 6645, Madison, WI 53716-0645.

SECTION I — BILLING PROVIDER INFORMATION

1. Provider ID	2. Name — Billing Provider	3. Taxonomy Code	4. Practice Location ZIP+4 Code
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SECTION II — MEMBER PERSONAL INFORMATION

5. Last Name — Member	6. First Name — Member	7. Middle Initial — Member
8. Previous Last Name — Member	9. Member Identification Number	10. Date of Birth (MM/DD/CCYY)

SECTION III — CERVICAL DIAGNOSTIC PROCEDURES

COLPOSCOPY WITH BIOPSY / ENDOCERVICAL CURETTAGE	COLPOSCOPY WITHOUT BIOPSY
11. Procedure Performed (Check One Box Only) <input type="checkbox"/> Colposcopy with Biopsy <input type="checkbox"/> Endocervical Curettage	21. Date Performed (MM/DD/CCYY)
12. Date Performed (MM/DD/CCYY)	22. Name — Rendering Provider (Print)
13. Name — Rendering Provider (Print)	23. RESULT (Check One Box Only) <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other Abnormality <input type="checkbox"/> Inflammation / Infection / HPV Changes <input type="checkbox"/> Unsatisfactory
14. RESULT (Check One Box Only) <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other Non-malignant Abnormality (HPV, Condyloma) <input type="checkbox"/> CIN 1 / Mild Dysplasia <input type="checkbox"/> CIN 2 / Moderate Dysplasia <input type="checkbox"/> CIN 3 / Severe Dysplasia / CIS <input type="checkbox"/> Invasive Squamous Cell Carcinoma <input type="checkbox"/> Adenocarcinoma	
LOOP ELECTROSURGICAL EXCISION PROCEDURE (LEEP)	COLD KNIFE CONE
15. Date Performed (MM/DD/CCYY)	24. Date Performed (MM/DD/CCYY)
16. Name — Rendering Provider (Print)	25. Name — Rendering Provider (Print)
17. RESULT (Check One Box Only) <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other Non-Malignant Abnormality (HPV, Condyloma) <input type="checkbox"/> CIN 1 / Mild Dysplasia <input type="checkbox"/> CIN 2 / Moderate Dysplasia <input type="checkbox"/> CIN 3 / Severe Dysplasia / CIS <input type="checkbox"/> Invasive Squamous Cell Carcinoma <input type="checkbox"/> Adenocarcinoma	26. RESULT (Check One Box Only) <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other Non-Malignant Abnormality (HPV, Condyloma) <input type="checkbox"/> CIN 1 / Mild Dysplasia <input type="checkbox"/> CIN 2 / Moderate Dysplasia <input type="checkbox"/> CIN 3 / Severe Dysplasia / CIS <input type="checkbox"/> Invasive Squamous Cell Carcinoma <input type="checkbox"/> Adenocarcinoma
ENDOMETRIAL BIOPSY	27. NOTES
18. Date Performed (MM/DD/CCYY)	
19. Name — Rendering Provider (Print)	
20. RESULT (Check One Box Only) <input type="checkbox"/> Negative / Normal Endometrium <input type="checkbox"/> Hyperplasia <input type="checkbox"/> Adenomatous Hyperplasia <input type="checkbox"/> Atypical Adenomatous Hyperplasia <input type="checkbox"/> Adenocarcinoma In-situ <input type="checkbox"/> Adenocarcinoma	

Shading indicates follow up required for WWWP.

28. RECOMMENDATION
 Follow Routine Screening Schedule _____ Months
 Short Term Follow up _____ Months
 Further Diagnostic Work Up
 Treatment*

*Not covered by WWWP.

Continued



SECTION III — CERVICAL DIAGNOSTIC PROCEDURES (Continued)

29. STATUS OF FINAL DIAGNOSIS (Check One Box Only)

- Complete* Pending Member Deceased Lost to Follow up Refused Work-up

*Must complete Element 30 (Final Diagnosis).

30. FINAL DIAGNOSIS (Required)

Date (MM/DD/CCYY) _____

- Normal / Benign / Inflammation HPV / Condyloma / Atypia CIN I / Mild Dysplasia
 CIN 2 / Moderate Dysplasia* CIN 3 / Severe Dysplasia / CIS* Invasive Cervical Cancer**
 Adenocarcinoma of the cervix** LSIL (Biopsy Diagnosis) HSIL (Biopsy Diagnosis)*

*Complete Treatment Date and Treatment Status. **Complete Treatment Date, Treatment Status, and Tumor Stage.

31. TUMOR STAGE (AJCC)

- Stage I Stage II Stage III Stage IV
-

32. TREATMENT STATUS — REQUIRED (Check One Box Only)

- Treatment Started
 Refused by Member
 Lost to Follow up
 Not Indicated / Not Needed
 Member Deceased
 Alternative Treatment (e.g., homeopathic therapy, herbal medicine, etc.)
-

33. TREATMENT DATE (MM/DD/CCYY)

ATTACHMENT 7

Calendar of ForwardHealth interChange Implementation Dates

Dates provided below are based on the implementation of ForwardHealth interChange on Monday, November 10, 2008.

October/November 2008						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
19 (October)	20	21	22	23	24 Last day ForwardHealth will accept from Medicaid, WCDP ¹ , and WWWP ² providers' paper claims completed using current claim instructions.	25
26	27 ForwardHealth will begin accepting from Medicaid, WCDP, and WWWP providers' paper claim forms completed using implementation claim instructions.	28	29	30	31 Deadline for accepting all current prior authorization (PA) forms (except PA/BMNA ³) via fax or mail — 1:00 p.m.	1 (November)
2	3 Deadline for accepting all electronic claim transactions from WWWP providers — 4:00 p.m. First day ForwardHealth will accept revised PA forms via mail. (Date stamped but not processed until November 10, 2008.)	4 Deadline for accepting all electronic claim transactions, including Point-of-Sale (POS), from WCDP providers — 4:00 p.m.	5 Deadline for accepting current screening and diagnostic reporting forms from WWWP providers — 4:00 p.m.	6	7 Deadline for accepting all electronic claim transactions, except POS, from Medicaid providers — 4:00 p.m. Deadline for accepting POS transactions from Medicaid providers — 8:00 p.m. Deadline for current STAT-PA ⁴ — 8:00 p.m.	8 New STAT-PA for drugs and POS available for Medicaid and WCDP pharmacies — 8:00 a.m. to 8:00 p.m.
9 New STAT-PA for drugs and POS again available for Medicaid and WCDP pharmacies — 8:00 a.m.	10 837 Health Care Claims, Provider Electronic Solutions (PES), and Portal are all available for Medicaid, WCDP, and WWWP providers for processing claims in interChange — 8:00 a.m. PA requests on the Portal now available — 8:00 a.m.	11	12	13	14	15

¹ WCDP: Wisconsin Chronic Disease Program.

² WWWP: Wisconsin Well Woman Program.

³ PA/BMNA: Prior Authorization/Brand Medically Necessary Attachment, HCF 11083 (dated 07/08).

⁴ STAT-PA: Specialized Transmission Approval Technology-Prior Authorization.

ATTACHMENT 8

UB-04 (CMS 1450) Claim Form Completion Instructions for Wisconsin Well Woman Program Services

**Effective for claims received on and after implementation of ForwardHealth
interChange.**

Use the following claim form completion instructions, *not* the form locator descriptions printed on the claim form, to avoid claim denial or inaccurate claim payment. Complete all form locators unless otherwise indicated. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-04 claim for Wisconsin Well Woman Program (WWWP). For complete billing instructions, refer to the National UB-04 Uniform Billing Manual prepared by the National Uniform Billing Committee (NUBC). The National UB-04 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-04 Uniform Billing Manual by calling (312) 422-3390 or by accessing the NUBC Web site at www.nubc.org/.

Members enrolled in the WWWP members receive a WWWP identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name.

Note: Each provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to ForwardHealth.

Submit completed paper claims to the following address:

WWWP
PO Box 6645
Madison WI 53716-0645

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, city, state, and ZIP +4 code. The name in Form Locator 1 should correspond with the NPI in Form Locator 56.

Form Locator 2 — Pay-to Name, Address, and ID (not required)

Form Locator 3a — Pat. Cntl # (optional)

Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance Advice (RA) and/or the 835 Health Care Claim Payment/Advice (835) transaction.

Form Locator 3b — Med. Rec. #

Enter the number assigned to the patient's medical/health record by the provider. This number will appear on the RA and/or the 835 transaction.

Form Locator 4 — Type of Bill

Exclude the leading zero and enter the three-digit type of bill code. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit (“X”) indicates the billing frequency; providers should enter one of the following for “X”:

- 1 = Admit through discharge claim.
- 2 = Interim — first claim.
- 3 = Interim — continuing claim.
- 4 = Interim — final claim.

Form Locator 5 — Fed. Tax No.

Data are required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider’s computer software is acceptable data for this element. If computer software does not automatically complete this element, enter information such as the provider’s federal tax identification number.

Form Locator 6 — Statement Covers Period (From - Through)

Enter both dates in MM/DD/YY format (e.g., November 1, 2006, would be 11/01/06). Include the date of discharge or death.

Form Locator 7 — Unlabeled Field (not required)

Form Locator 8a-b — Patient Name

Enter the member’s last name and first name, separated by a space or comma, in Form Locator 8b. Use Wisconsin’s Enrollment Verification System (EVS) to obtain the correct spelling of the member’s name. If the name or spelling of the name on the WWWP card and the EVS do not match, use the spelling from the EVS.

Form Locator 9a-e — Patient Address

Data are required in this element for OCR processing. Any information populated by a provider’s computer software is acceptable data for this element (e.g., “On file”). If computer software does not automatically complete this element, enter information such as the member’s complete address in field 9a.

Form Locator 10 — Birthdate

Enter the member’s birth date in MMDDCCYY format (e.g., September 25, 1975, would be 09251975).

Form Locator 11 — Sex

Form Locator 12 — Admission Date

Enter the admission date in MM/DD/YY format (e.g., November 1, 2001, would be 11/01/01).

Form Locator 13 — Admission Hr (not required)

Form Locator 14 — Admission Type (not required)

Form Locator 15 — Admission Src (not required)

Enter the code indicating the source of this admission. Refer to the UB-04 Billing Manual for more information.

Form Locator 16 — DHR (not required)

Form Locator 17 — Stat (not required)

Form Locators 18-28 — Condition Codes (not required)

Form Locator 29 — ACDT State (not required)

Form Locator 30 — Unlabeled Field (not required)

Form Locators 31-34 — Occurrence Code and Date (not required)

Form Locators 35-36 — Occurrence Span Code (From - Through) (not required)

Form Locator 37 — Unlabeled Field (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount

Enter the relevant value code and associated amount, if applicable. Refer to the UB-04 Billing Manual for more information on value codes.

Form Locator 42 — Rev. Cd.

Enter the appropriate four-digit revenue code as defined by the NUBC that identifies a specific accommodation or ancillary service.

Form Locator 43 — Description (not required)

Form Locator 44 — HCPCS/Rate/HIPPS Code (required)

Form Locator 45 — Serv. Date

Enter the single “from” date of service (DOS) in MMDDYY format in this form locator.

Form Locator 46 — Serv. Units

Enter the number of covered accommodation days or ancillary units of service for each line item.

Form Locator 47 — Total Charges (by Accommodation/Ancillary Code Category)

Enter the usual and customary charges for each line item.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field

Enter the “to” DOS in DD format. A range of consecutive dates may be indicated only if the revenue code, the procedure code (and modifiers, if applicable), the service units, and the charge were identical for each date within the range.

Detail Line 23

PAGE ___ OF ___

Enter the current page number in the first blank and the total number of pages in the second blank. This information must be included for both single- and multiple-page claims.

CREATION DATE (not required)

TOTALS

Enter the sum of all charges for the claim in this field. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim.*

Form Locator 50 A-C — Payer Name

Enter all health insurance payers here. Enter “WWWP” for WWWP and the name of the commercial health insurance, if applicable. If submitting a multiple-page claim, enter health insurance payers only on the *first page* of the claim.

Form Locator 51 A-C — Health Plan ID (not required)**Form Locator 52 A-C — Rel. Info (not required)****Form Locator 53 A-C — Asg. Ben. (not required)****Form Locator 54 A-C — Prior Payments (required, if applicable)**

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, “OI-P” must be indicated in Form Locator 80.) If the commercial health insurance denied the claim, enter “000.” Do **not** enter Medicare-paid amounts in this field.

If submitting a multiple-page claim, enter the amount paid by commercial health insurance only on the *first page* of the claim.

Form Locator 55 A-C — Est. Amount Due (not required)**Form Locator 56 — NPI**

Enter the provider’s National Provider Identifier (NPI). The NPI in Form Locator 56 should correspond with the name in Form Locator 1.

Form Locator 57 — Other Provider ID (not required)

Enter the provider number in this element. The provider number in Form Locator 57 should correspond with the name in Form Locator 1.

Form Locator 58 A-C — Insured’s Name

Data are required in this element for OCR processing. Any information populated by a provider’s computer software is acceptable data for this element (e.g., “Same”). If computer software does not automatically complete this element, enter information such as the member’s last name, first name, and middle initial.

Form Locator 59 A-C — P. Rel (not required)**Form Locator 60 A-C — Insured’s Unique ID**

Enter the member identification number. Do not enter any other numbers or letters. Use the WWWP card or the EVS to obtain the correct member ID.

Form Locator 61 A-C — Group Name (not required)**Form Locator 62 A-C — Insurance Group No. (not required)****Form Locator 63 A-C — Treatment Authorization Codes (not required)****Form Locator 64 A-C — Document Control Number (not required)****Form Locator 65 A-C — Employer Name (not required)****Form Locator 66 — Dx (not required)**

Form Locator 67 — Prin. Diag. Cd.

Enter the valid, most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include “E” (etiology) codes.

Form Locators 67A-Q — Other Diag. Codes

Enter valid, most specific ICD-9-CM diagnosis codes (up to five digits) corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Diagnoses that relate to an earlier episode and have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 68 — Unlabeled Field (not required)**Form Locator 69 — Admit Dx (not required)**

Enter a valid, most specific ICD-9-CM diagnosis code (up to five digits) provided at the time of admission.

Form Locator 70 — Patient Reason Dx (not required)**Form Locator 71 — PPS Code (not required)****Form Locator 72 — ECI (not required)****Form Locator 73 — Unlabeled Field (not required)****Form Locator 74 — Principal Procedure Code and Date (not required)****Form Locator 74a-e — Other Procedure Code and Date (not required)****Form Locator 75 — Unlabeled Field (not required)****Form Locator 76 — Attending (not required)****Form Locator 77 — Operating (not required)**

Enter the operating provider’s NPI.

Form Locators 78 and 79 — Other (not required)

Enter the other provider’s NPI.

Form Locator 80 — Remarks (enter information when applicable)***Commercial Health Insurance Billing Information***

Commercial health insurance coverage must be billed prior to billing ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

When the member has dental (“DEN”), Medicare Cost (“MCC”), Medicare + Choice (“MPC”) insurance only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 80.

When the member has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), vision only (“VIS”), a health maintenance organization (“HMO”), or

some other (“OTH”) commercial health insurance, *and* the service requires commercial health insurance billing, then one of the following three other insurance (OI) explanation codes *must* be indicated in Form Locator 80. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to the following: <ul style="list-style-type: none"> • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member’s commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not submit claims to ForwardHealth for services that are included in the capitation payment.

Medicare Information

Use Form Locator 80 for Medicare information. Submit claims to Medicare before billing ForwardHealth.

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates the provider is not Medicare certified.

Note: Home health agencies, medical equipment vendors, pharmacies, and physician services providers must be Medicare certified to perform Medicare-covered services for dual eligibles.

- Medicare has allowed the charges. In this case, attach Medicare remittance information, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-7	<p>Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances.</p> <p><i>For Medicare Part A, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. <p><i>For Medicare Part B, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances.</p> <p><i>For Medicare Part A, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis). <p><i>For Medicare Part B, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as certified for Medicare Part B. • The member is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Form Locator 81 a-d — CC (not required)

If the billing provider's NPI was indicated in Form Locator 56, enter the qualifier "B3" in the first field to the right of this form locator, followed by the 10-digit provider taxonomy code in the second field.

ATTACHMENT 9

Sample UB-04 Claim Form for Wisconsin Well Woman Program Services

1 IM BILLING HOSPITAL 1 W. WILSON ANYTOWN WI 55555-1234 (444) 444-4444		2		3a PAT. CNTL. # b. MED. REC. # 03 7654321		4 TYPE OF BILL 131	
8 PATIENT NAME a		9 PATIENT ADDRESS b		5 FED. TAX NO. 01-2345678		6 STATEMENT COVERS PERIOD FROM 110308	
7 THROUGH 110308		ON FILE					
d MEMBER, IM A							
10 BIRTHDATE 09251975		11 SEX F		12 DATE 110308		13 HR X	
14 TYPE		15 SRC		16 DHR		17 STAT	
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28 29 ACOT STATE 30							
31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE		34 CODE	
35 OCCURRENCE DATE		36 CODE		37 OCCURRENCE DATE		38 CODE	
39 CODE		VALUE CODES AMOUNT		40 CODE		VALUE CODES AMOUNT	
a		80		1.00		41 CODE	
b						42 VALUE CODES AMOUNT	
c						43 VALUE CODES AMOUNT	
d						44 VALUE CODES AMOUNT	
42 REV. CD		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
0320				77057 TC		110308	
				77055 TC		110308	
						46 SERV. UNITS	
						1.0	
						1.0	
						47 TOTAL CHARGES	
						XX XX	
						XX XX	
						48 NON-COVERED CHARGES	
						01	
						01	
PAGE 1 OF 1							
CREATION DATE							
TOTALS → XX XX							
50 PAYER NAME WWWP		51 HEALTH PLAN ID		52 REL. REF. ID		53 ADD. BULK	
						54 PRIOR PAYMENTS	
						55 EST. AMOUNT DUE	
						56 NPI 0111111110	
						57 OTHER PRV ID	
58 INSURED'S NAME SAME		59 P. REL.		60 INSURED'S UNIQUE ID 1234567890		61 GROUP NAME	
						62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
66 DX V76.10		67		68			
69 ADMIT DX 9661		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
73							
74 PRINCIPAL PROCEDURE DATE		a OTHER PROCEDURE DATE		b OTHER PROCEDURE DATE		75	
c OTHER PROCEDURE DATE		d OTHER PROCEDURE DATE		e OTHER PROCEDURE DATE		76 ATTENDING NPI 022222220	
						QUAL	
						FIRST	
						QUAL	
						FIRST	
80 REMARKS		81 CD a		b		77 OPERATING NPI	
		B3 123456789X				QUAL	
						FIRST	
						QUAL	
						FIRST	
						QUAL	
						FIRST	

ATTACHMENT 10

Sample Incorrectly Completed UB-04 Claim Form for Wisconsin Well Woman Program Services

Information circled in the claim form below is a noncovered Wisconsin Well Woman Program service.

1 IM BILLING HOSPITAL 1 W. WILSON ANYTOWN WI 55555-1234 (444) 444-4444										2										3a PAT. CNTL. # b. MED. REC. # 03 7654321					4 TYPE OF BILL 131																																																																																				
5 FED. TAX NO. 01-2345678										6 STATEMENT COVERS PERIOD FROM 110308 THROUGH 110308					7																																																																																														
8 PATIENT NAME a										9 PATIENT ADDRESS b ON FILE										c					d																																																																																				
10 BIRTHDATE 09251975										11 SEX F					12 DATE 110308					13 HR					14 TYPE X					15 SRC					16 DHR					17 STAT					18					19					20					21					22					23					24					25					26					27					28					29 ACOT STATE					30				
31 OCCURRENCE CODE										32 OCCURRENCE DATE					33 OCCURRENCE CODE					34 OCCURRENCE DATE					35 OCCURRENCE SPAN FROM					36 OCCURRENCE SPAN THROUGH					37																																																																										
38										39 VALUE CODES AMOUNT a 80					40 VALUE CODES AMOUNT b 1.00					41 VALUE CODES AMOUNT c					42																																																																																				
43 REV. CD 0320										44 HCR / STATE / HIPPS CODE 77058					45 SERV. DATE 110308					46 SERV. UNITS 1.0					47 TOTAL CHARGES XX XX					48 NON-COVERED CHARGES					49 01																																																																										
PAGE 1 OF 1										CREATION DATE										TOTALS					XX XX																																																																																				
50 PAYER NAME WWWP										51 HEALTH PLAN ID					52 REL. INFO					53 ADJ. BLN					54 PRIOR PAYMENTS					55 EST. AMOUNT DUE					56 NPI 0111111110																																																																										
58 INSURED'S NAME SAME										59 P.REL.					60 INSURED'S UNIQUE ID 1234567890					61 GROUP NAME					62 INSURANCE GROUP NO.																																																																																				
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER					65 EMPLOYER NAME																																																																																														
66 DX V76.10										68																																																																																																			
69 ADMIT DX 9661										70 PATIENT REASON DX					71 PPS CODE					72 EGI					73																																																																																				
74 PRINCIPAL PROCEDURE CODE										75 OTHER PROCEDURE CODE					76 ATTENDING NPI 022222220					77 OPERATING NPI																																																																																									
78 OTHER PROCEDURE CODE										79 OTHER PROCEDURE CODE					80 REMARKS B3 123456789X					81 OTHER NPI					82 OTHER NPI																																																																																				

ATTACHMENT 11

Adjustment/Reconsideration Request Completion Instructions

(A copy of the “Adjustment/Reconsideration Request Completion Instructions” is located on the following pages.)

(This page was intentionally left blank.)

FORWARDHEALTH
ADJUSTMENT / RECONSIDERATION REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

ForwardHealth members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The Adjustment/Reconsideration Request, F-13046, is used by ForwardHealth to request an adjustment of an allowed claim (a paid or partially paid claim). Providers may request an adjustment when claim data need to be changed or corrected. After the changes are made to the original claim, the adjusted claim is processed.

Providers cannot adjust a totally denied claim. A claim that was totally denied must be resubmitted after the necessary corrections have been made.

Questions about adjustments and other procedures or policies may be directed to Provider Services at (800) 947-9627.

The Adjustment/Reconsideration Request is reviewed by ForwardHealth based on the information provided. Providers may photocopy the Adjustment/Reconsideration Request for their own use. Providers should be as specific as possible when describing how the original claim is to be changed. Providers may also attach a copy of the corrected claim.

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

The provider should mail the Adjustment/Reconsideration Request to the appropriate mailing address:

BadgerCare Plus
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

WCDP
PO Box 6410
Madison WI 53716-0410

WWWP
PO Box 6645
Madison WI 53716-0645

INSTRUCTIONS

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

SECTION I — BILLING PROVIDER AND MEMBER INFORMATION

Check the appropriate box to indicate the applicable program to which the adjustment request is being submitted.

Element 1 — Name — Billing Provider

Enter the billing provider's name.

Element 2 — Billing Provider's Provider ID

Enter the Provider ID of the billing provider.

Element 3 — Name — Member

Enter the complete name of the member for whom payment was received.

Element 4 — Member Identification Number

Enter the member ID.

SECTION II — CLAIM INFORMATION (Non-Pharmacy)

Element 5 — Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date

Enter the date of the remittance advice or the payment date or check issue date from the 835.

Element 6 — Internal Control Number / Payer Claim Control Number

Enter the internal control number (ICN) from the remittance advice or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the ICN assigned to the most recently processed claim or adjustment.)

Add a new service line(s).

Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

Correct detail on previously paid/allowed claim.

Check if correcting details on a previously paid or allowed claim.

Element 7 — Date(s) of Service

Enter to and from date(s) of service (DOS) in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date. If grouping services, the place of service, procedure code, charges, and rendering provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive dates. The number of days must correspond to the number of units in Element 24G of the 1500 Health Insurance Claim Form.

Element 8 — POS

Enter the appropriate two-digit POS code for each service.

Element 9 — Procedure / NDC / Revenue Code

Enter the single most appropriate procedure code. ForwardHealth will deny claims received without an appropriate procedure code, National Drug Code (NDC), or revenue code. When adjusting a detail that includes an NDC and a "J" code, providers are required to attach a paper claim form to the adjustment request and follow the claim form instructions for submitting the NDC.

Element 10 — Modifiers 1-4

Enter the appropriate modifier(s).

Element 11 — Billed Amount

Enter the total billed amount for each line item. Providers are to indicate their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

Element 12 — Unit Quantity

Enter the number of units. Only include a decimal when billing fractions (e.g., 1.50).

Element 13 — Family Planning Indicator

Enter a "Y" for each family planning procedure when applicable.

Element 14 — EMG

Emergency Indicator. Enter a "Y" for each procedure performed as an emergency. If the procedure is not an emergency, leave this element blank. Dental providers should continue to enter an "E" to indicate each procedure performed as an emergency.

Element 15 — Rendering Provider Number

Health care providers may enter their NPI and taxonomy code. Non-healthcare providers may enter their Provider ID.

SECTION II — CLAIM INFORMATION (Pharmacy)

Element 5 — Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date

Enter the date of the remittance advice or the payment date or check issue date from the 835.

Element 6 — Internal Control Number / Payer Claim Control Number

Enter the ICN from the remittance advice or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the ICN assigned to the most recently processed claim or adjustment.)

Add a new service line(s).

Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

Correct detail on previously paid/allowed claim.

Check if correcting details on a previously paid or allowed claim.

Element 7 — Date(s) of Service

Enter the date filled in MM/DD/YY or MM/DD/CCYY format for each NDC in the "From" field.

Element 8 — POS

Enter the appropriate two-digit National Council for Prescription Drug Programs (NCPDP) patient location code for each NDC billed.

Element 9 — Procedure / NDC / Revenue Code

Enter the NDC. Claims received without an appropriate NDC will be denied.

Element 10 — Modifiers 1-4

Not applicable for pharmacy claims.

Element 11 — Billed Amount

Enter the total billed amount for each line item. Providers are to indicate their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

Element 12 — Unit Quantity

Enter the metric decimal quantity in the specified unit of measure according to the ForwardHealth drug file. Quantities billed should be rounded to two decimal places (i.e., nearest hundredth).

Element 13 — Family Planning Indicator

Not applicable for pharmacy claims.

Element 14 — EMG

Not applicable for pharmacy claims.

Element 15 — Rendering Provider Number

Not applicable for pharmacy claims.

SECTION III — ADJUSTMENT INFORMATION

Note: Additional information necessary for adjustment/reconsideration of an NDC should be included in Element 16 under "Other/comments."

Element 16 — Reason for Adjustment

Check one of the following boxes indicating the provider's reason for submitting the adjustment:

- *Consultant review requested.* Indicate if there are extenuating circumstances or complicated or new procedures and attach a history and physical operative or anesthesia report.
- *Recoup entire payment.* This would include claims billed in error or completely paid by another insurance carrier.
- *Other insurance payment.* Enter the amount paid by the other insurance carrier.
- *Copayment deducted in error.* Indicate if the member was a nursing home resident on the DOS, the correct number of covered service days, or if an emergency service was provided.
- *Medicare reconsideration.* Attach both the original and the new Medicare remittance information.
- *Correct service line.* Provide specific information in the comments section or attach a corrected claim.
- *Other / comments.* Add any clarifying information not included above.*

Element 17 — Signature — Billing Provider**

Authorized signature of the billing provider.

Element 18 — Date Signed**

Use either the MM/DD/YY format or the MM/DD/CCYY format.

Element 19 — Claim Form Attached

Indicate if a corrected claim form is attached. Although this is optional, ForwardHealth encourages providers to attach a corrected claim form when adding additional service lines or correcting information from a previously adjusted claim.

* This section of the Adjustment/Reconsideration Request form should be used for any pharmacy-specific fields (e.g., prescription number) pertaining to the NDC being adjusted or added to a previously processed claim. If either the Submission Clarification Code or the Unit Dose value is being adjusted on a drug claim, both values must be indicated in the comment area, even if one is not being adjusted.

** If the date or signature is missing on the Adjustment/Reconsideration Request form, the adjustment request will be denied.

ATTACHMENT 12

Adjustment/Reconsideration Request

(A copy of the "Adjustment/Reconsideration Request" is located on the following page.)

**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: 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 Maintain a copy of this form for your records.

