

**FORWARDHEALTH  
PROVIDER SUGGESTION**

The Division of Medicaid Services is interested in improving its program for providers and members. Providers who feel any policy or procedure stated in provider publications should be revised or who wish to suggest new policies are encouraged to submit recommendations. Providers may attach additional pages if needed. Send the completed form to the following address:

Division of Medicaid Services  
Bureau of Benefits Management  
PO Box 309  
Madison WI 53701-0309

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

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**SECTION I – PROVIDER INFORMATION**

Name – Provider	Provider Number
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Address
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City	State	Zip Code
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Contact Name	Phone Number
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Email
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Suggestion
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**SECTION II – PUBLICATION INFORMATION (IF APPLICABLE)**

Publication Number	Publication Title	Date Published
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Question / Problem
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Suggestion
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