DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01016 (01/2018)

STATE OF WISCONSIN

RESET FORM

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.

SECTION I – PROVIDER INFORMATION

Name – Provider	Provider Number	
Address		
City	State	Zip Code
Contact Name	Phone Number	
Email		
Suggestion		

SECTION II – PUBLICATION INFORMATION (IF APPLICABLE)

Publication Number	Publication Title	Date Published
Question / Problem		
Suggestion		