FORWARDHEALTH
COMMERCIAL OTHER COVERAGE DISCREPANCY REPORT
COMPLETION INSTRUCTIONS

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

Members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. Per Wis. Admin. Code § DHS 104.02(4), this information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number.

Personally identifiable information about applicants and members is confidential and is only used for purposes directly related to program administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the Commercial Other Coverage Discrepancy Report form, F-01159, may result in denial of payment for the services.

Provision of a Social Security number (SSN) is mandatory under the provisions of the Affordable Care Act. The SSN will be used for coordination of benefits purposes. Use or disclosure of any information concerning a policyholder (including a policyholder's billing information or medical claim records) for any purpose not connected with program administration is prohibited unless authorized by the policyholder (program administration includes contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

This form is mandatory; use an exact copy of this form. ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form. Attach additional pages if more space is needed.

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.

Type or print clearly. Providers may use this form to notify ForwardHealth of discrepancies between other health care coverage information obtained through Wisconsin's Enrollment Verification System (EVS) and information received from another source. Always complete Sections I and V. Complete Sections II, III, and/or IV as appropriate. ForwardHealth will verify the information provided and update the member's file (if applicable). **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.**

INSTRUCTIONS

SECTION I – PROVIDER AND MEMBER INFORMATION

Element 1 – Name – Provider
Required. Enter the provider's name.

Element 2 – Provider ID/National Provider Identifier
Required. Enter the provider's National Provider Identifier (NPI) or Medicaid provider ID.

Element 3 – Name – Member
Required. Enter the member's complete name.

Element 4 – Date of Birth – Member
Required. Enter the member's date of birth in MM/DD/CCYY format.

Element 5 – Member ID
Required. Enter the member's Medicaid member ID.

SECTION II – COMMERCIAL HEALTH INSURANCE AND MEDICARE SUPPLEMENTAL COVERAGE

Element 6
Required. Indicate whether the policy type is being added, changed, or deleted from the member's insurance.

Element 7 – Policy Type
Required. Indicate the policy being added, changed, or deleted is commercial, Medicare Supplemental, or Long-Term Care (LTC) Only.

Element 8 – Carrier Number
Required. Enter the number associated with the insurance company, found on the EVS. Providers can access the EVS to receive the most current enrollment information through the following methods:
- ForwardHealth Portal at *www.forwardhealth.wi.gov/*
- WiCall, Wisconsin's automated voice response system, at 800-947-3544
- Commercial enrollment verification vendors
- 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transactions
- ForwardHealth Provider Services call center at 800-947-9627

Element 9 – Name – Insurance Company
Required. Enter the name of the insurance company.

Element 10 – Address – Insurance Company (Required)
Required. Enter the insurance company's address (street, city, state, and ZIP code).

Element 11 – Name – Policyholder
Required. Enter the policyholder's last name, first name, and middle initial.

Element 12 – Social Security Number – Policyholder
Required. Enter the policyholder's SSN.

Element 13 – Date of Birth – Policyholder
Required. Enter the policyholder's date of birth.

Element 14 – Gender – Policyholder
Required. Indicate the policyholder's gender.

Element 15 – Relationship to Member – Policyholder
Required. Indicate the policyholder's relationship to the member.

Element 16 – Group Number
Required. Enter the group number.

Element 17 – Policy Number
Required. Enter the policy number.

Element 18 – Commercial or Medicare Supplemental Coverage Codes
Situational. Indicate whether the commercial or Medicare Supplemental coverage is drug, major medical physician, dental, inpatient hospital, outpatient hospital, nursing home, vision, durable medical equipment (DME) rental, DME purchase, or home health. Check all applicable options as defined in the following table.

Coverage Code	Definition
Dental	Insurance for dental costs, including the routine preventive care, treatment and care of dental disease, and accidents to teeth.
Drug	Insurance plan that covers all or some of the cost of pharmaceutical medications. Generally these plans are part of a commercial health insurance plan. Insurers can provide these benefits in-house or contract with a Pharmacy Benefit Manger (PBM) to provide these benefits. These plans do not include: discount drug programs or drug coverage associated with Medicare Advantage or Medicare Cost Plans.
DME Purchase	Insurance for medical equipment used in the course of treatment or home care, including such items as crutches, knee braces, wheelchairs, hospital beds, prostheses, etc., that a plan member can purchase.
DME Rental	Insurance for medical equipment used in the course of treatment or home care, including such items as crutches, knee braces, wheelchairs, hospital beds, prostheses, etc., that a plan member can rent.
Home Health	Insurance for intermittent home nursing care, home health aide services, various types of therapy, medical supplies, medication prescribed under the home care plan, and nutrition counseling.
Inpatient Hospital	Insurance for the admission to health facilities that provide board and room, for the purpose of observation, care, diagnosis, or treatment. Inpatient care tends to be directed towards more serious ailments and trauma that require one or more days of overnight stay at a hospital. For the purposes of healthcare coverage, health insurance plans require the member to be formally admitted into a hospital for a stay for a service to be considered inpatient.
Major Medical Physician	Insurance for acute care and routine preventive care. This can include primary care visits and specialty care.
Nursing Home	Insurance for medical services rendered by registered or licensed practical nurses, physical therapists, occupational therapists, and speech therapists, for members who have often been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip, and patients requiring complicated wound care.
Outpatient Hospital	Insurance for ambulatory care at an outpatient department or clinic without room and board provided, for 24 hours or less. Outpatient care is medical service that does not require a prolonged stay at a facility. This can include routine services such as checkups or visits to clinics. Surgical procedures, so long as they allow the member to leave the hospital or facility on the same day, can still be considered as outpatient care.
Vision	Insurance for routine preventive eye care and prescription eyewear. These plans typically provide specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. Some vision insurance policies also offer discounts on refractive surgery, such as LASIK and PRK.

Element 19 – LTC Coverage Only
Situational. Indicate whether the LTC coverage is LTC Only Cash or LTC Only Claims Reimbursement. Long-Term Care Only Cash describes a policy that pays out a set dollar amount per day when a member cannot perform activities of daily living. Long-Term Care Only Claims Reimbursement describes a policy that requires the submission of a medical claim for reimbursement.

Element 20 – Coverage Start Date
Required. Enter the member's coverage start date. This element is required.

Element 21 – Open-Ended Coverage?
Required. Indicate whether or not the member's coverage is open-ended.

Element 22 – Coverage End Date
Situational. If the member does not have open-ended coverage, enter the member's coverage end date. This element is required if "No" is selected in Element 21.

SECTION III – REPORT INFORMATION

Element 23 – Name – Individual Completing This Report
Required. Enter the name of the individual completing this report.

Element 24 – Date Report Completed
Required. Enter the date the report was completed.

Element 25 – Telephone Number/Extension
Required. Enter the telephone number, including the area code, and extension of the individual completing this report.

Element 26 – Name – Source of Information Included on This Report
Required. Enter the name of the individual who provided the information included on this report.

Element 27 – Telephone Number/Extension
Required. Enter the telephone number, including the area code, and extension of the individual who provided the information included on this report.

Element 28 – Comments
Enter any additional comments in the space provided.