FORWARDHEALTH
EXPLANATION OF MEDICAL BENEFITS 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. 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.

Under Wis. Stat. § 49.45(4), 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 claim information for other health insurance. Alternate versions will not be accepted.

Submit the completed Explanation of Medical Benefits form, F-01234, with a completed paper claim form by mail to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Providers are required to retain a copy of the completed form in the member's records.

INSTRUCTIONS

Providers are required to submit a separate Explanation of Medical Benefits form for each payer that has processed the claim prior to ForwardHealth (also known as a "primary payer"). Primary payers may be Medicare, Medicare Advantage, or commercial insurance.

Explanation of Medical Benefits forms for up to five different primary payers will be allowed for each claim. Each Explanation of Medical Benefits form allows for up to 12 details of explanation of benefits (EOB) information to be added **for a single primary payer**. Additional Explanation of Medical Benefits forms can be attached, as follows:

- First Explanation of Medical Benefits form – complete all sections of the form (both front and back).
- Additional Explanation of Medical Benefits forms for the same payer – complete Section I; Section II, Element 3; and Section V. Leave Sections III and IV blank.

Note: When indicating negative numbers on the Explanation of Medical Benefits form, providers are required to place the hyphen in front of the number that is being indicated as negative. Providers may **not** use a hyphen following the number or parenthesis around the number to indicate that it is negative as the information will not be captured correctly.

SECTION I – PAYER INFORMATION

Element 1 is a required element.

Element 1

Check the appropriate box to indicate whether the primary payer is Medicare, Medicare Advantage, or commercial insurance. If commercial insurance, enter the name of the commercial insurance, if known, in the space provided.

Check **one** box only. If more than one box is checked in Element 1 on the Explanation of Medical Benefits form, the claim will be returned to the provider unprocessed.

SECTION II – MEMBER INFORMATION
Elements 2 through 4 are required elements.

Element 2 – Name – Member
Enter the last name, first name, and middle initial of the member.

Element 3 – Member ID
Enter the 10-digit Medicaid member ID or 11-character Medicare member ID. This number must correspond to the member ID on the 1500 Health Insurance Claim Form or UB-04 (CMS 1450) Claim Form as well as any additional Explanation of Medical Benefits forms. If the details continue onto page 2 of the Explanation of Medical Benefits form, enter the member ID listed in this element in the space provided at the top of the page.

Element 4 – Relationship to Policyholder
Indicate the member's relationship to the policyholder using the following codes.

Code	Relationship
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ donor
40	Cadaver donor
53	Life partner
G8	Other relationship

SECTION III – PRIMARY POLICYHOLDER INFORMATION
Elements 5 through 7 are required elements.

Element 5 – Name – Primary Policyholder
Enter the name of the primary payer policyholder.

Element 6 – Primary Policy ID
Enter the primary payer policyholder's ID number or Medicare member ID.

Element 7 – Policy / Group Number
Enter the primary payer policyholder's policy or group number.

SECTION IV – HEADER ADJUDICATION INFORMATION
Providers are required to complete this section if the primary payer processed the claim at the header level. If the primary payer did not supply header-level information, this section may be left blank. If this section is left blank, providers are required to complete Section V. The claim will be returned to the provider unprocessed if both Sections IV and V on the Explanation of Medical Benefits form are left blank.

Note: Professional crossover claims require that both the header and detail adjudication (Section V) information be completed in order to be processed.

If other insurance indicator Y or Medicare disclaimer code 8 is indicated in Element 11, then Element 8 and Elements 12 through 21 may be left blank.

Note: Instructions for mid-stay Medicare benefits, exhausted or gained, are found at the end of this section, following Element 21.

Element 8 – Date Payer Processed
Enter the date the primary payer processed the claim in MM/DD/CCYY format.

Element 9 – From Date of Service
Enter the from date of service (DOS) in MM/DD/CCYY format.

Element 10 – To Date of Service
Enter the to DOS in MM/DD/CCYY format.

Element 11 – Paid / Deny
Primary payers must be billed prior to submitting claims to ForwardHealth, unless the service does not require primary payer billing as determined by ForwardHealth.

If Wisconsin's Enrollment Verification System (EVS) indicates that the member has any primary payer, and the service requires primary payer billing, one of the following must be indicated in Element 11:

- Non-dental providers – If the EVS indicates that the member has dental ("DEN") insurance only, then an Explanation of Medical Benefits form is not required with the claim. If the EVS indicates that the member has any other commercial health insurance, and the service requires other insurance billing, then one of the other insurance indicators or Medicare disclaimer codes from the following table must be indicated in Element 11 on the Explanation of Medical Benefits form.
- Dental providers – Commercial health insurance or dental insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth. Commercial health insurance coverage is indicated by the EVS under Other Commercial Health Insurance. ForwardHealth has identified specific Current Dental Terminology (CDT) procedure codes that must be billed to other insurance sources prior to being billed to ForwardHealth. Additionally, ForwardHealth has defined a set of other insurance indicators for dental services. (Refer to the Commercial Health Insurance chapter of the Coordination of Benefits section in the Dental service area of the ForwardHealth Online Handbook.)

Commercial Payers	
Indicator	**Description**
P	PAID in part or in full by commercial insurance, or payment was applied toward the member's cost share (that is, coinsurance, copayment, and deductible).
Commercial Insurance Payers Only	
Indicator	**Description**
D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim. Do not use this code unless the claim was actually billed to the commercial health insurer.
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: • 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 other insurance indicator D or 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 bill ForwardHealth for services that are included in the capitation payment.	

Medicare Primary Payers – An Explanation of Medical Benefits form is **not** required for Medicare when one or more of the following statements is true:

- Medicare does not cover the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage, including a Medicare Advantage Plan, 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 that the provider is not Medicare-enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medical Benefits form but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, the Explanation of Medical Benefits form is required, and if Medicare denied the claim, a Medicare disclaimer code is necessary.

Medicare or Medicare Advantage Payers Only

Disclaimer Code	Description
7	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. For Medicare Part A, use code 7 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in 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 exhausted benefits. For Medicare Part B, use code 7 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in 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 exhausted benefits. Note: This can be entered as either M7 or 7.
8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. For Medicare Part A, use code 8 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in 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 (for example, member's diagnosis). For Medicare Part B, use code 8 in the following instances (all three criteria must be met): • The provider is identified in ForwardHealth files as enrolled in 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 (for example, member's diagnosis). Note: This can be entered as either M8 or 8.

Element 12 – Billed Amount
Enter the total billed amount from the claim form being submitted.

Element 13 – Allowed
Enter the amount allowed by the primary payer.

Element 14 – Paid
If other insurance indicator P is indicated in Element 11, enter the total amount paid by the primary payer for the entire claim. If other insurance indicator D or Y or Medicare disclaimer code 7 or 8 is indicated in Element 11, enter zero.

Element 15 – Coins PR 2
If the primary payer EOB indicates coinsurance (PR 2), enter the total primary payer coinsurance amount for the claim.

Element 16 – Deductible PR 1
If the primary payer EOB indicates deductible (PR 1), enter the total primary payer deductible amount for the claim.

Element 17 – Noncovered CO 96
If the primary payer EOB indicates noncovered (CO 96), enter the total primary payer noncovered amount for the claim.

Element 18 – Copay PR 3
If the primary payer EOB indicates copayment (PR 3), enter the total primary payer copayment amount for the claim.

Element 19 – Blood Deduct PR 66
If the primary payer EOB indicates blood deductible (PR 66), enter the total primary payer blood deductible amount for the claim.

Element 20 – Psych Reduct PR 122
If the primary payer EOB indicates psychiatric reduction (PR 122), enter the total primary payer psychiatric reduction amount for the claim.

Element 21 – ANSI Reason Codes
If the primary payer EOB indicates any other American National Standards Institute (ANSI) reason codes not included in Elements 15 through 20, enter the additional ANSI reason codes and their dollar amounts as indicated by the primary payer.

If the sum of Elements 13 through 20 does **not** equal the billed amount indicated in Element 12, the difference must be accounted for in this element.

Note: When indicating the ANSI reason group code (for example, CO PR), providers should **not** use a hyphen between the reason group code and the ANSI reason code, or the system may interpret the ANSI reason code as a negative number (for example, rather than indicating CO-45, providers should indicate CO 45).

Instructions for Dual-Eligibility During Inpatient Stay
Use the following billing instructions for dual-eligible members when Medicare Part A benefits are exhausted during an inpatient hospital stay or when a member gains Medicare Part A benefits mid-stay.

Bill Medicare for all inpatient charges, including the Medicare Part B charges, and for all Medicare Part B billable ancillaries during the noncovered Medicare Part A days. Any professional component charges should be billed to Medicare on the 1500 Health Insurance Claim Form.

On the UB-04 claim form, use value code “AB” in Form Locators 39–41 a–d, and state the total Medicare allowed amount for Medicare Part B services (not the Medicare payment amount). In Form Locators 31–34, use occurrence code “C3” and indicate the date the Medicare Part A benefits were exhausted.

Fill out the Explanation of Medical Benefits form as indicated by the table below.

Section or Field	Instructions
Sections I–III: Fill out as instructed.	
Section IV:	
Field 8	Enter the date Medicare processed the claim.
Fields 9 and 10	Enter **only** the dates Medicare covered the service within the “From Date of Service” and “To Date of Service” fields.
Field 11	Enter Medicare Disclaimer Code 7. (Note: This can be entered either as M7 or 7.)
Field 12	Enter the amount billed to Medicare.
Field 14	Enter the amount paid by Medicare.
Fields 15–21	Leave the Medicare Member Cost Share and/or other ANSI Claim Adjustment Reason Code fields blank.
Section V: Leave blank.	

SECTION V – DETAIL ADJUDICATION INFORMATION
Providers are required to complete this section if the primary payer processed the claim at the detail level. If the primary payer did not supply detail-level information, providers may leave this section blank. If this section is left blank, providers are required to complete Section IV. The claim will be returned to the provider unprocessed if both Sections IV and V on the Explanation of Medical Benefits form are left blank.

Note: Professional crossover claims require that both the header (Section IV) and detail adjudication information be completed in order to be processed.

Enter a detail number in the first column for each detail line on the claim form and complete Elements 22 through 37 as they correspond to the details on the claim form. If the details continue onto page 2 of the Explanation of Medical Benefits form, enter the member ID from Element 3 of the Explanation of Medical Benefits form in the space provided at the top of the page.

Element 22 – Date Payer Processed
Enter the date the primary payer processed the claim in MMDDCCYY format.

Element 23 – From Date of Service
Enter the from DOS in MMDDCCYY format.

Element 24 – To Date of Service
Enter the to DOS in MMDDCCYY format.

Element 25 – Paid / Deny
Primary payers must be billed prior to submitting claims to ForwardHealth, unless the service does not require primary payer billing as determined by ForwardHealth.

If the EVS indicates that the member has any primary payer, and the service requires primary payer billing, one of the following must be indicated in Element 25:

- Non-dental providers – If the EVS indicates that the member has dental ("DEN") insurance only, then an Explanation of Medical Benefits form is not required with the claim. If the EVS indicates that the member has any other commercial health insurance, and the service requires other insurance billing, then one of the other insurance indicators or Medicare disclaimer codes from the following table must be indicated in Element 25 of the Explanation of Medical Benefits form.
- Dental providers – Commercial health insurance or dental insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth. Commercial health insurance coverage is indicated by the EVS under Other Commercial Health Insurance. ForwardHealth has identified specific CDT procedure codes that must be billed to other insurance sources prior to being billed to ForwardHealth. Additionally, ForwardHealth has defined a set of other insurance indicators for dental (refer to the Commercial Health Insurance chapter of the Coordination of Benefits section in the Dental service area of the ForwardHealth Online Handbook).

Commercial Payers	
Indicator	**Description**
P	PAID in part or in full by commercial insurance, or payment was applied toward the member's cost share (that is, coinsurance, copayment, and deductible).
Commercial Insurance Payers Only	
Indicator	**Description**
D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim. Do not use this code unless the claim was actually billed to the commercial health insurer.
Note: The provider may not use other insurance indicator D 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 bill ForwardHealth for services that are included in the capitation payment.	

Medicare Primary Payers – An Explanation of Medical Benefits form is **not** required for Medicare when one or more of the following statements are true:

- Medicare does not cover the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage, including a Medicare Advantage Plan, 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 that the provider is not Medicare-enrolled.

If Medicare has allowed the charges, attach the completed Explanation of Medical Benefits form.

Element 26 – Billed Amount
Enter the primary payer amount billed on the detail.

Element 27 – Proc. Code
Enter the procedure code from the detail, if applicable.

Element 28 – Revenue Code
Enter the revenue code from the detail, if applicable.

Element 29 – Allowed
Enter the primary payer allowed amount from the detail.

Element 30 – Paid
If other insurance indicator P is entered in Element 25, enter the total amount paid by the primary payer for that detail. If other insurance indicator D or Medicare disclaimer code 7 or 8 is indicated in Element 25, enter zero.

Element 31 – Coins PR 2
If the primary payer EOB indicates coinsurance (PR 2), enter the primary payer coinsurance amount for the detail.

Element 32 – Deductible PR 1
If the primary payer EOB indicates deductible (PR 1), enter the primary payer deductible for the detail.

Element 33 – Noncovered CO 96
If the primary payer EOB indicates noncovered (CO 96), enter the primary payer noncovered amount for the detail.

Element 34 – Copay PR 3
If the primary payer EOB indicates copayment (PR 3), enter the primary payer copayment for the detail.

Element 35 – Blood Deduct PR 66
If the primary payer EOB indicates blood deductible (PR 66), enter the primary payer blood deductible amount for the detail.

Element 36 – Psych Reduct PR 122
If the primary payer EOB indicates psychiatric reduction (PR 122), enter the primary payer psychiatric reduction amount for the detail.

Element 37 – ANSI Reason Codes
If the primary payer EOB indicates any other ANSI reason codes not included in Elements 31 through 36, enter the additional ANSI reason codes and their dollar amounts as indicated by the primary payer.

If the sum of Elements 29 through 36 does **not** equal the billed amount indicated in Element 26, the difference must be accounted for in this element.

Note: When indicating the ANSI reason group code (for example, CO PR), providers should **not** use a hyphen between the reason group code and the ANSI reason code, or the system may interpret the ANSI reason code as a negative number (for example, rather than indicating CO-45, providers should indicate CO 45).