**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services

F-02074 (04/2018)

**FORWARDHEALTH**

**MEDICARE OTHER COVERAGE DISCREPANCY REPORT**

**INSTRUCTIONS:** Providers may use this form to notify ForwardHealth of discrepancies between other health care coverage information obtained through Wisconsin’s Enrollment Verification System 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). Refer to the Medicare Other Coverage Discrepancy Report Instructions, F-02074A, for more information. **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. Type or print clearly.**

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.

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| **SECTION I – PROVIDER AND MEMBER INFORMATION** |
| 1. Name – Provider      | 2. Provider ID / National Provider Identifier      |
| 3. Name – Member (Last, First, Middle Initial)      |
| 4. Date of Birth – Member      | 5. Medicaid Member ID      | 6. Social Security Number      |
| 7. Gender[ ]  Male [ ]  Female [ ]  Unknown | 8. Medicare Member ID      |
| **SECTION II – MEDICARE PARTS A and B** |
| 9. [ ]  Add [ ]  Change [ ]  Delete | 10. [ ]  Part A [ ]  Part B |
| **SECTION III – MEDICARE ADVANTAGE AND MEDICARE COST COVERAGE**  |
| 11. [ ]  Add [ ]  Change [ ]  Delete | 12. [ ]  Medicare Advantage [ ]  Medicare Cost |
| 13. Carrier Number      |
| 14. Name – Insurance Company      |
| 15. Address – Insurance Company (Street, City, State, ZIP Code) (Required)      |
| 16. Group Number      | 17. Policy Number      |
| *Note:* If the coverage start and end dates are unknown or open-ended, leave Elements 18, 19, and 20 blank and explain the issue in the Comments field of Section V of this form.  |
| 18. Coverage Start Date      | 19. Open-Ended Coverage?[ ]  Yes [ ]  No | 20. Coverage End Date (Required if Open-Ended Coverage = No)      |
| 21. [ ]  Yes [ ]  No | 22. Date Member Left HMO Service Area (If Applicable)      |

*Continued*

**MEDICARE OTHER COVERAGE DISCREPANCY REPORT** 2 of 2

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| **SECTION IV – MEDICARE PART D**  |
| 23. [ ]  Add [ ] Change [ ]  Delete | 24. Is Medicare Part D coverage provided through Medicare Advantage Plan in Section III? [ ]  Yes [ ]  No |
| 25. Carrier Number      |
| 26. Name – Insurance Company      |
| 27. Address – Insurance Company (Street, City, State, ZIP Code) (Required)      |
| 28. Group Number      | 29. Policy Number      |
| *Note:* If the coverage start and end dates are unknown or open-ended, leave these fields blank and explain the issue in the Comments field of Section V of this form.  |
| 30. Coverage Start Date (Required)      | 31. Open-Ended Coverage? [ ]  Yes [ ]  No | 32. Coverage End Date (Required if Open-Ended Coverage = No)      |
| 33. Member Left HMO Service Area[ ]  Yes [ ]  No | 34. Date Member Left HMO Service Area (If Applicable)      |
| **SECTION V – REPORT INFORMATION** |
| 35. Name – Individual Completing This Report      |
| 36. Date Signed      | 37. Telephone Number / Extension      |
| 38. Name – Source of Information Included on This Report      | 39. Telephone Number / Extension      |
| 40. Comments      |
| (Attach a copy of the applicable insurance card.) |