DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02074 (04/2018)

STATE OF WISCONSIN

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.

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. 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. Member Left HMO Service Area ❑ Yes ❑ No	22. Date Member Left HMO Service Area (If Applicable)	

Continued

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.)