FORWARDHEALTH
MEDICARE 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 Medicare Other Coverage Discrepancy Report form, F-02074, 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 National Provider Identifier (NPI) or Medicaid provider ID of the provider.

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

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

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

Element 6 – Social Security Number
Required. Enter the member's SSN.

Element 7 – Gender
Required. Indicate the member's gender.

Element 8 – Medicare Beneficiary ID Number or Health Insurance Claim Number
Enter the member's Medicare Beneficiary ID number or Health Insurance Claim Number.

SECTION II – MEDICARE PARTS A AND B
Elements 9 and 10 are required if the discrepancy relates to Medicare Parts A or B coverage.

Element 9
Indicate whether Medicare Part A or B is being added, changed, or deleted from the member's insurance.

Element 10
Indicate whether the addition, change, or deletion is for Medicare Part A or Part B.

SECTION III – MEDICARE ADVANTAGE AND MEDICARE COST COVERAGE
Elements 11–19 and 21–22 are required if the discrepancy relates to Medicare Advantage or Medicare Cost coverage. Element 20 is required if the response to Element 19 is No.

Element 11
Indicate whether Medicare Advantage or Medicare Cost is being added, changed, or deleted from the member's insurance.

Element 12
Indicate whether the addition, change, or deletion is for Medicare Advantage or Medicare Cost. Medicare Advantage and Medicare Cost both describe types of Medicare Part C coverage offered by commercial insurance companies to take the place of Medicare coverage for members with Medicare Parts A and B benefits, except for hospice and clinical trials. Medicare Advantage offers this through HMOs, preferred provider organizations, private fee-for-service plans, special needs plans, or Medicare medical saving account plans. For members with Medicare Cost, Medicare covered services received outside the insurance carrier's provider network revert to Medicare Part A or Part B, if the service was not an emergency or obtained with a referral.

Element 13 – Carrier Number
Enter the number associated with the insurance company, found on the EVS.

Element 14 – Name – Insurance Company
Enter the name of the insurance company.

Element 15 – Address – Insurance Company (Required)
Enter the insurance company's address (street, city, state, and ZIP code).

Element 16 – Group Number
Enter the group number.

Element 17 – Policy Number
Enter the policy number.

Element 18 – Coverage Start Date
Enter the member's coverage start date.

Element 19
Indicate whether or not the member's coverage is open ended.

Element 20 – Coverage End Date
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 19.

Element 21 – Member Left HMO Service Area
Indicate whether or not the member left the HMO service area.

Element 22 – Date Member Left HMO Service Area
Enter the date the member left the HMO service area if "Yes" is selected in Element 21.

SECTION IV – MEDICARE PART D
Elements 23 and 24 are required if the discrepancy relates to Medicare Part D.

Element 23
Indicate whether Medicare Part D is being added to, changed, or deleted from the member's insurance.

Element 24
Indicate whether or not Medicare Part D coverage is provided through the same Medicare Advantage or Medicare Cost Plan noted in Section III, if applicable.

Element 25 – Carrier Number
Enter the number associated with the insurance company, found on the EVS.

Element 26 – Name – Insurance Company
Enter the insurance company's name.

Element 27 – Address – Insurance Company (Required)
Enter the insurance company's address, including the street, city, state, and ZIP code.

Element 28 – Group Number
Enter the group number.

Element 29 – Policy Number
Enter the policy number.

Element 30 – Coverage Start Date
Enter the member's start date of coverage.

Element 31
Indicate whether or not the member's coverage is open ended. Open-ended coverage means that the policy is active and there is not a termination date.

Element 32 – Coverage End Date
If the response to Element 31 is "no," enter the end date for the member's coverage.

Element 33 – Member Left HMO Service Area
Indicate whether or not the member left the HMO service area.

Element 34 – Date Member Left HMO Service Area
If the response to Element 33 is "yes," enter the date the member left the HMO service area.

SECTION V – REPORT INFORMATION

Element 35 – Name – Individual Completing This Report
Required. Enter the name of the individual completing this report.

Element 36 – Date Report Completed
Required. Enter the date the report was completed.

Element 37 – Telephone Number/Extension
Required. Enter the telephone number, including the area code, and extension of the individual completing this report.

Element 38 – Name – Source of Information Included on This Report
Required. Enter the name of the individual who provided the information included on this report.

Element 39 – 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 40 – Comments
Enter any additional comments in the space provided.