**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services

F-13046 (02/2025)

**FORWARDHEALTH**

**ADJUSTMENT / RECONSIDERATION REQUEST**

**INSTRUCTIONS:** Type or print clearly. Refer to the Adjustment/Reconsideration Request Instructions, F‑13046A, for information about completing this form.

The provider is required to maintain a copy of this form for their records.

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| **SECTION I – BILLING PROVIDER AND MEMBER INFORMATION** |
| Indicate the appropriate program.[ ]  BadgerCare Plus / SeniorCare / Wisconsin Medicaid [ ]  Wisconsin Chronic Disease Program (WCDP)[ ]  Children’s Long-Term Support (CLTS) Program [ ]  Wisconsin Well Women Program (WWWP)[ ]  Wisconsin HIV Drug Assistance Program (HDAP) |
| 1. Name – Billing Provider      | 2. Medicaid-Assigned Provider ID      |
| 3. Name – Member      | 4. Member ID Number      |
| **SECTION II – CLAIM INFORMATION** |
| 5. Remittance Advice (RA) or X12 835 Health Care Claim Payment / Advice (835) Report Date, Check Issue Date, or Payment Date      | 6. Internal Control Number / Payer Claim Control Number      |
| [ ]  Add a new service line(s) to previously paid / allowed claim. (In Elements 7–15, enter information to be added.)[ ]  Correct detail on previously paid / allowed claim. (In Elements 7–12, enter information as it appears on the RA or 835.) |
| 7. Dates of Service  | FromTo |       |       |       |       |
|       |       |       |       |
| 8. Place of Service |       |       |       |       |
| 9. Procedure / National Drug Code / Revenue Code |       |       |       |       |
| 10. Modifiers 1–4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
|    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 11. Billed Amount |       |       |       |       |
| 12. Unit Quantity |       |       |       |       |
| 13. Family Planning Indicator\* |       |       |       |       |
| 14. Emergency Indicator\* |       |       |       |       |
| 15. Rendering Provider Number |       |       |       |       |

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| **SECTION III – ADJUSTMENT INFORMATION** |
| 16. Reason for Adjustment[ ]  Consultant review requested (Include supporting documentation.)[ ]  Recoup entire payment[ ]  Other insurance—dental / pharmacy with OI-P $     [ ]  Other insurance—professional / institutional / CLTS (Attach Explanation of Medical Benefits form, F-01234.)[ ]  Copayment deducted in error [ ]  Member in nursing home [ ]  Covered days       [ ]  Emergency[ ]  Primary payer reconsideration[ ]  Correct service line[ ]  Correct or update prior authorization number[ ]  Other / comments      |
| 17. **SIGNATURE –** Billing Provider | 18. Date Signed |
| 19. Claim Form Attached (Optional)[ ]  Yes [ ]  No |

\* This element does not apply to CLTS providers.