**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.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | From  To |  | | | |  | | | | |  | | | | |  | | | |
|  | | | |  | | | | |  | | | | |  | | | |
| 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 | |  | | | |  | | | | |  | | | | |  | | | |

|  |  |
| --- | --- |
| **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.