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 PROV	IDER	AND	MEM	BER II	NFO	RMAT	ION											
Indicate the appropriate program.																		
BadgerCare Plus / SeniorCare / Wisconsin Medicaid										Chronic Disease Program (WCDP)								
Children's Long-Term Support (CLTS) Program									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.) 								or										
7. Dates of Service 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	1
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.