**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services

F-13066 (08/2012)

**FORWARDHEALTH**

**CLAIM REFUND**

**Instructions:** Type or print clearly. Maintain a copy of this form for the member’s records. Mail this form and either the ForwardHealth-issued check or the provider-issued refund check to the applicable address for either Wisconsin Medicaid, Wisconsin Chronic Disease Program (WCDP), or Wisconsin Well Woman Program (WWWP):

Wisconsin Medicaid WCDP WWWP

Financial Services Cash Unit PO Box 6410 PO Box 6645

313 Blettner Blvd Madison WI 53716-0410 Madison WI 53716-0645

Madison WI 53784

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| SECTION I — BILLING PROVIDER AND MEMBER INFORMATION | | | | | | | | |
| Indicate applicable program.  Wisconsin Medicaid  WCDP  WWWP | | | | | | | | |
| 1. Payee / Billing Provider's Provider Number | | | 2. Name — Payee / Billing Provider | | | | | |
| 3. Member Identification Number | | | 4. Name — Member | | | | | |
| **SECTION II — CLAIM INFORMATION** | | | | | | | | |
| 5. Payer Control Number / Internal Control Number | | | 6. Check Issue Date / Report Date | | | | | |
| 7. Date(s) of Service  From To | | 8. Procedure Code / National Drug Code / Revenue Code | 9. Modifiers 1-4  Mod 1 Mod 2 Mod 3 Mod 4 | | | | 10. Billed Amount | 11. Refund Amount |
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|  | | | | | | | 12. Refund Total | |
| **SECTION III — REFUND INFORMATION** | | | | | | | | |
| 13. Reason for Refund (Check one.)  Medicare paid.  Overpayment.  Other commercial health or dental insurance payment (OI-P) $     .  Not our patient.  Wrong date of service.  Duplicate payment by ForwardHealth.  Billing error.  Other / Comments. | | | | | | | | |