**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 1-4Mod 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.       |