

## WISCONSIN MEDICAID AND BADGERCARE PLUS MANAGED CARE PROGRAM PROVIDER APPEAL INSTRUCTIONS

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is only used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of prior authorization or payment of service. The use of this form is voluntary.

### INSTRUCTIONS

BadgerCare Plus and Medicaid Supplemental Security Income (SSI) managed care providers are required to appeal the non-payment or partial payment from the HMO before filing an appeal to ForwardHealth if they disagree with the HMO's appeal response. Failure to appeal to the HMO first as required will result in the appeal being returned unprocessed. The provider should refer to the signed contract with the HMO or the HMO-specific website's provider resources to verify appeal rights and responsibilities (for example, claim filing timelines, prior authorization request requirements, and coordination of benefits requirements). The provider's signed contract with the HMO may control the final decision.

Providers are required to submit appeals to ForwardHealth in writing within 60 calendar days of the HMO's final decision or, in the case of no response, within 60 calendar days from the 45-calendar day timeline allotted to the HMO to respond to the provider's appeal submission.

Appeals will only be reviewed for members who are enrolled in a BadgerCare Plus HMO or Medicaid SSI HMO on the date of service in question.

Providers are required to submit an appeal with legible copies of all of the following using either the Managed Care Program Provider Appeal form, F-12022, or their own appeal letter:

- The original claim submitted to the HMO and all corrected claims submitted to the HMO
- All of the HMO's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim denial
- The provider's written appeal to the HMO
- The HMO's response to the provider's appeal
- Relevant medical documentation that supports appeals regarding coding issues or emergency determination
- Any contract language that supports the appeal with the exact language that supports overturning the payment denial indicated
- Any other documentation that supports the appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort)

Only the relevant documentation should be included. Large documents may be submitted on a CD.

Appeals may be faxed to ForwardHealth at 608-224-6318 or mailed to the following address:

BadgerCare Plus and Medicaid SSI  
Managed Care Unit – Provider Appeal  
PO Box 6470  
Madison WI 53716-0470

The provider is required to notify ForwardHealth if the HMO subsequently reprocesses and pays the claim for which the provider has submitted an appeal.

### SECTION I – PROVIDER INFORMATION

#### Element 1: Name – Provider Filing Appeal

Enter the name of the provider.

#### Element 2: Phone Number – Provider Filing Appeal

Enter the phone number, including the area code, of the provider.

#### Element 3: Address – Provider Filing Appeal

Enter the address of the provider, including the street, city, state, and zip code.

**Element 4: Secure Email Address – Provider**

Enter the provider's secure email address. Only secure email should be used to transmit documents that contain personal health information.

**Element 5**

Indicate whether or not the provider has a contractual arrangement with the HMO. Include a copy of any contractual language that addresses or supports the provider's appeal. Do not send a copy of the entire contract; be sure to identify only the relevant contract language.

**Element 6: Name – Contact Person**

Enter the name of the contact person for this appeal.

**Element 7: Phone Number – Contact Person**

Enter the phone number, including the area code, of the contact person for this appeal.

**Element 8: Name – BadgerCare Plus / Medicaid SSI HMO Involved**

Enter the name of the BadgerCare Plus/Medicaid SSI HMO.

**SECTION II – MEMBER INFORMATION**

**Element 9: Name – BadgerCare Plus / Medicaid SSI HMO Member**

Enter the name of the BadgerCare Plus/Medicaid SSI HMO member.

**Element 10: Member ID Number**

Enter the member ID.

**Element 11: Date(s) of Service**

Enter the date(s) the member received service.

**SECTION III – DESCRIPTION OF PROBLEM**

**Element 12**

Describe the problem in detail. Attach additional pages if necessary. Attach copies of all required documents and any other supporting documentation relevant to the problem.

**Element 13**

Enter the date the appeal was sent to the BadgerCare Plus/Medicaid SSI HMO. An appeal to the HMO is required before submitting an appeal to ForwardHealth. Attach a copy of the appeal to the HMO.

**Element 14**

Enter the date the appeal was denied by the BadgerCare Plus/Medicaid SSI HMO. Attach a copy of the HMO denial.

**Element 15**

Describe what response was received from the BadgerCare Plus/Medicaid SSI HMO. Attach a copy of any relevant correspondence.

**Element 16**

Describe what the provider considers to be a fair resolution of the matter.

**SECTION IV – SIGNATURE**

**Element 17: Signature – Provider**

The provider is required to complete and sign this form.

**Element 18: Date Signed**

Enter the month, day, and year the form was signed in mm/dd/ccyy format.