DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Health Care Access and Accountability
F-13046 (08/15)

FORWARDHEALTH
ADJUSTMENT / RECONSIDERATION REQUEST

Instructions: Type or print clearly. Refer to the Adjustment/Reconsideration Request Completion Instructions, F-13046A, for information about completing this form.

The provider is required to maintain a copy of this form for his or her records.

SECTION I — BILLING PROVIDER AND MEMBER INFORMATION

Indicate appropriate program.

❑ BadgerCare Plus / SeniorCare / Wisconsin Medicaid ❑ ADAP ❑ WCDP ❑ WWWP

1. Name — Billing Provider	2. Billing Provider's Provider ID
3. Name — Member	4. Member Identification 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. Date(s) of Service From	To	8. POS	9. Procedure / NDC / Revenue Code	10. Modifiers 1-4 Mod 1	Mod 2	Mod 3	Mod 4	11. Billed Amount	12. Unit Quantity	13. Family Planning Indicator	14. EMG	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 (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.
❑ Other / comments.

17. **SIGNATURE —** Billing Provider	18. Date Signed

19. Claim Form Attached (Optional)

❑ Yes ❑ No