DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services
F-01159 (04/2017)

FORWARDHEALTH

COMMERCIAL OTHER COVERAGE DISCREPANCY REPORT

Instructions: Providers may use this form to notify ForwardHealth of discrepancies between other health care coverage information obtained through Wisconsin's Enrollment Verification System and information received from another source. All three sections of this form must be completed. ForwardHealth will verify the information provided and update the member's file (if applicable). Refer to the Commercial Other Coverage Discrepancy Report Completion Instructions, F-01159A, for more information. **Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly. Type or print clearly.**

Submit the completed form by fax to Coordination of Benefits at 608-221-4567 or by mail to the following address:

ForwardHealth
Coordination of Benefits
PO Box 6220
Madison WI 53716-6220

Allow five to seven business days for processing.

SECTION I – PROVIDER AND MEMBER INFORMATION

1. Name – Provider	2. Provider ID / National Provider Identifier
3. Name – Member (Last, First, Middle Initial)	
4. Date of Birth – Member	5. Member ID

SECTION II – COMMERCIAL HEALTH INSURANCE AND MEDICARE SUPPLEMENTAL COVERAGE

6. ❑ Add ❑ Change ❑ Delete	7. Policy Type ❑ Commercial ❑ Medicare Supplemental ❑ Long-Term Care (LTC)
8. Carrier Number	
9. Name – Insurance Company	
10. Address – Insurance Company (Street, City, State, ZIP Code)	
11. Name – Policyholder (Last, First, Middle Initial)	
12. Social Security Number – Policyholder	13. Date of Birth – Policyholder
14. Gender – Policyholder ❑ Male ❑ Female ❑ Unknown	15. Relationship to Member – Policyholder ❑ Self ❑ Spouse ❑ Child ❑ Stepchild ❑ Other
16. Group Number	17. Policy Number

Continued

SECTION II – COMMERCIAL HEALTH INSURANCE AND MEDICARE SUPPLEMENTAL COVERAGE (Continued)

18. Commercial or Medicare Supplemental Coverage Codes (Check all applicable options.)

- ❑ Dental
- ❑ Drug
- ❑ Durable Medical Equipment (DME) Purchase
- ❑ DME Rental
- ❑ Home Health
- ❑ Inpatient
- ❑ Major Medical Physician
- ❑ Nursing Home
- ❑ Outpatient
- ❑ Vision

19. LTC Coverage Only (Check only one option.)

- ❑ LTC Only Cash
- ❑ LTC Only Reimbursement

20. Coverage Start Date (Required)	21. Open-Ended Coverage? ❑ Yes ❑ No	22. Coverage End Date (Required if Open-Ended Coverage = No)

SECTION III – REPORT INFORMATION

23. Name – Individual Completing This Report	24. Date Report Completed

25. Telephone Number / Extension

26. Name – Source of Information Included on This Report	27. Telephone Number / Extension

28. Comments

(Attach a copy of the applicable insurance card.)

Reset Form