DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-13066 (08/2012)

STATE OF WISCONSIN

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
Financial Services Cash Unit
313 Blettner Blvd
Madison WI 53784

WCDP
PO Box 6410
Madison WI 53716-0410

WWWP
PO Box 6645
Madison WI 53716-0645

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
							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.

Reset Form