Division of Medicaid Services F-13046 (02/2025)

## FORWARDHEALTH ADJUSTMENT / RECONSIDERATION REQUEST

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

The provider is required to maintain a copy of this form for their records.

SECTION I – BILLING PROV	IDER	AND	MEM	BER IN	OF	RMAT	ION											
Indicate the appropriate progra	am.																	
☐ BadgerCare Plus / SeniorCare / Wisconsin Medicaid ☐ Wisconsin										Chronic Disease Program (WCDP)								
☐ Children's Long-Term Support (CLTS) Program							☐ Wisconsin Well Women Program (WWWP)											
☐ Wisconsin HIV Drug Assistance Program (HDAP)																		
1. Name – Billing Provider		2. Medicaid-Assigned Provider ID																
3. Name – Member									4. Member ID 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												
<ul> <li>□ Add a new service line(s) to previously paid / allowed claim. (In Elements 7–15, enter information to be added.)</li> <li>□ Correct detail on previously paid / allowed claim. (In Elements 7–12, enter information as it appears on the RA or 835.)</li> </ul>																		
7. Dates of Service																		
To To																		
8. Place of Service																		
9. Procedure / National Drug Code / Revenue Code																		
10. Modifiers 1–4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
11. Billed Amount																		
12. Unit Quantity																		
13. Family Planning Indicator*																		
14. Emergency Indicator*																		
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 / CLTS (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								
☐ Correct or update prior authorization number								
☐ Other / comments								
17. <b>SIGNATURE –</b> Billing Provider	18. Date Signed							
19. Claim Form Attached (Optional)								
☐ Yes ☐ No								

<sup>\*</sup> This element does not apply to CLTS providers.