DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-01159 (09/12)

STATE OF WISCONSIN

FORWARDHEALTH

OTHER COVERAGE DISCREPANCY REPORT

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members.

Members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Personally identifiable information about applicants and members is confidential and is used for purposes directly related to program administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the services.

This form is mandatory; use an exact copy of this form. ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form. Attach additional pages if more space is needed.

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. Always complete Sections I and IV. Complete Sections II and/or III as appropriate. ForwardHealth will verify the information provided and update the member's file (if applicable). **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.**

Allow five to seven business days for processing.

SECTION I — PROVIDER AND MEMBER INFORMATION

Name — Provider	Provider ID	
Name — Member (Last, First, Middle Initial)	Date of Birth — Member	Member Identification Number

SECTION II — MEDICARE PART A AND B COVERAGE

Member Medicare / HIC Number

❑ Add		❑ Change	
❑ Part A Coverage	Start Date	❑ Part A Coverage	End Date
❑ Part B Coverage	Start Date	❑ Part B Coverage	End Date

SECTION III — COMMERCIAL HEALTH INSURANCE, MEDICARE SUPPLEMENTAL, AND MEDICARE MANAGED CARE COVERAGE

❑ Add	❑ HMO	❑ Medicare Managed Care
❑ Change	❑ Medicare Supplement	❑ Other

Name — Insurance Company

Address — Insurance Company (Street, City, State, ZIP Code)

Name — Policyholder (Last, First, Middle Initial)		Social Security Number — Policyholder
Policy Number	Coverage Start Date	Coverage End Date

Member Left HMO Service Area ❑ Yes ❑ No	Date Member Left HMO Service Area (If Applicable)

Continued

SECTION IV — REPORT INFORMATION

Name — Individual Completing This Report	Date Signed	Telephone Number / Extension

Name — Source of Information Included on This Report	Telephone Number / Extension

Mail to	Fax to	Comments
ForwardHealth Coordination of Benefits PO Box 6220 Madison WI 53716-6220	Coordination of Benefits (608) 221-4567	(Attach copy of insurance card.)