FORWARDHEALTH
WRITTEN CORRESPONDENCE INQUIRY

ForwardHealth requires certain information to enable the program 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, Wis. Admin. Code § DHS 104.0(4).

Under Wis. Stat. § 49.45(4), personally identifiable information about program 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.

The use of this form is voluntary; providers may develop their own form as long as it includes all the information on this form. Attach additional pages if more space is needed.

INSTRUCTIONS
Complete only the first page of this form. The provider will receive a letter from Provider Services after the inquiry is resolved. For more information on submitting written inquiries, contact Provider Services at 800-947-9627. Retain a copy of this inquiry and send the original to ForwardHealth, Written Correspondence, 313 Blettner Boulevard, Madison, WI 53784.

SECTION I — PROVIDER INFORMATION

Name — Provider	Provider ID
Name — Contact Person	Telephone Number — Contact Person
Address — Provider	

SECTION II — CLAIM / ADJUSTMENT IN QUESTION

Name — Member (Last, First, Middle Initial)		Member ID
Claim Number	Date(s) of Service (MM/DD/CCYY)	Amount Billed $
Date of Remittance Advice (RA) (MM/DD/CCYY)		Explanation of Benefits Code(s)
Other Information		

Reason for Inquiry

- ❑ Provider Services could not assist with the claim denial in question (Explain below).
- ❑ Provider Services or Professional Relations representative advised writing (Explain below).
- ❑ Inquiry involves extensive documentation or research (Explain below).
- ❑ Other (Briefly explain the situation in question below).

SIGNATURE — Provider	Date Signed

Continued

(THIS PAGE IS FOR FORWARDHEALTH USE ONLY.)

SECTION III — REQUEST FOR FURTHER INFORMATION

In order to complete research on an inquiry, ForwardHealth needs the following information. Send the information checked below to Written Correspondence, along with all the materials originally sent to Written Correspondence.

- ❑ Provider ID
- ❑ Member Name and 10-digit Member ID
- ❑ Copy of Any Previous Response Related to the Inquiry
- ❑ Date of Service
- ❑ Amount Billed
- ❑ Other (Briefly explain the situation in question below.)
- ❑ Copy of the RA
- ❑ Copy of the Claim in Question
- ❑ Copy of the Medicare Explanation of Medicare Benefits
- ❑ Copy of the Adjustment in Question
- ❑ Record of Treatment Dates

Reset Form