DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 13046 (Rev. 06/03)

STATE OF WISCONSIN

WISCONSIN MEDICAID
ADJUSTMENT / RECONSIDERATION REQUEST

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

1. Name — Billing Provider	2. Billing Provider's Medicaid Provider Number
3. Name — Recipient	4. Recipient Medicaid Identification Number

SECTION II — CLAIM INFORMATION

5. Remittance and Status (R/S) Report Date / Check Issue Date	6. Internal Control Number / Payer Claim Control Number

☐ Add new service line(s) to previously paid/allowed claim (in Elements 7-15, enter information to be added).

7. Date(s) of Service From	To	8. POS	9. Procedure / NDC / Revenue Code	10. Modifiers 1-4 Mod 1	Mod 2	Mod 3	Mod 4	11. Billed Amount	12. Unit Quantity	13. Family Plan	14. EMG	15. Performing Provider

SECTION III — ADJUSTMENT INFORMATION

16. Reason for Adjustment:

- ❑ Consultant review requested.
- ❑ Recoup entire Medicaid payment.
- ❑ Other Insurance Payment (OI-P) **$**_____.
- ❑ Copayment deducted in error: ❑ Patient in nursing home. ❑ Covered days _____. ❑ Emergency.
- ❑ Medicare reconsideration (Attach the Explanation of Medicare Benefits).
- ❑ Correct service line. (Provide specific information in the comments section below or attach a corrected claim.)
- ❑ Other/Comments:

17. **SIGNATURE** — Provider	18. Date Signed
Mail to: Wisconsin Medicaid Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002	19. Claim Form Attached (Optional) ❑ Yes ❑ No

Maintain a copy of this form for your records.

Reset Form