

## **Guidelines for Completing the General Services Claim Form**

1. Bill *only* non-residential services on the General Services Claim Form. Residential services such as “room & board” or “care & supervision” must be billed on a Residential Claim Form. The use of the incorrect form will result in the denial of the claim.
2. **To avoid denial of claims:**
  - Use the correct form.
  - Complete and mail the form only after the last “To Date of Service”.
  - Verify all information is accurate and complete.
  - Enter all required information per instructions.
  - Type/write legibly or complete the fillable claim form available online at [www.carewisc.org](http://www.carewisc.org) on the “Providers” page. Typewritten claims are preferred, as handwritten claims cannot be scanned and may cause delays in processing.
  - Bill in whole units, not fractions of units.
  - Enter dollar amounts to include cents (e.g. 254.78 or 234.00).
3. Please use the information in your Care Wisconsin contract and the Service Authorization letter you received from Care Wisconsin to complete this claim form. If you are uncertain about how to complete this claim form, it is essential that you contact the Care Wisconsin Provider Help Desk at (608) 245-3053 or toll free (877) 496-3858 (weekdays 8:30 am to 4:00 pm) prior to billing so you can receive assistance.

The following pages provide you with instructions on accurately completing a Care Wisconsin General Services Claim Form.  
Please keep for your records.

## Care Wisconsin General Services Claim Form Instructions

Use the instructions below to complete your General Services claim form. The numbers on the claim form match to the numbers on the instruction sheet.

### Member Information Section:

Use the Authorization Letter or call the Provider Help Desk to obtain the correct Member information.

1. Care Wisconsin Member Identification #: Enter the member's 9 digit Care Wisconsin Member ID#.
- 2a. Member Last Name: Enter the Member's last name.
- 2b. Member First Name: Enter the Member's first name. Please use the member's legal name, not a nickname (e.g. William rather than Bill).
- 2c. Member Middle Initial: Enter the Member's middle initial. If blank, leave blank on claim form.
3. Member Date of Birth: Enter Member's date of birth using the following format MM/DD/YY (e.g. 04/02/10 or 12/15/10).
4. Diagnosis Code: Enter as the diagnosis code **V689**.

### Provider Information Section:

5. Provider NPI: If you have a national Provider Identification Number (NPI), enter your number. If you do not have a NPI, leave blank.
6. Care Wisconsin Provider ID: Enter your Care Wisconsin Provider ID shown on the cover letter of your final signed Care Wisconsin Contract.
7. Provider Tax ID: Enter the Tax Identification Number for the organization listed in item 8, Provider legal name. The provider tax ID must match the ID provided on the W-9 form.
8. Provider Legal Name: Enter the name shown on the Care Wisconsin Contract.
9. Billing Address: Enter the street address for the Provider entered in # 8 above.
10. City/State/Zip Code: Enter the City, State and Zip Code of the Provider entered in # 8 above.
11. Service Location Name: Enter Service Location name as shown on the Care Wisconsin Contract.
12. Service Location Address: Enter street address of Service Location entered in # 11.
13. City/State/Zip Code: Enter the City, State, and Zip Code of the Service Location entered in #11

**Billed Services Section:**

**14. Date of Service:**

**From Date:** Enter the first date of service for the period you are billing for on this claim.

**To Date:** If service is being provided every day with no breaks enter the last date of service for the period you are billing for on this claim.

If there is a gap in service, you must bill on separate lines for each continuous period of service, as “Dates of Service” must represent the actual dates the service was provided (see Figure 1). If there are breaks in service, each “To Date” is the last date service was provided to the member.

**Figure 1**

14. Date of Service (MM/DD/YY) (Date Span or Individual Days) From Date To Date		15. Place of Service	16. CPT/HCPCS Code	17. Modifier	18. Service Description	19. Units Billed	20. (\$) Rate per Unit	21. (\$) Total Charges
07/01/10	07/15/10					15		
07/20/10	07/31/10					11		
								22. (\$) Total Charges

**Figure 2**

14. Date of Service (MM/DD/YY) (Date Span or Individual Days) From Date To Date		15. Place of Service	16. CPT/HCPCS Code	17. Modifier	18. Service Description	19. Units Billed	20. (\$) Rate per Unit	21. (\$) Total Charges
07/02/10	07/02/10							
07/05/10	07/05/10							
07/10/10	07/10/10							
07/20/10	07/20/10							
								22. (\$) Total Charges

**15. Place of Service:** Enter Place of Service Code from the list below:

If you are unsure of which code to use, please contact the Provider Help Desk.

- |                            |                                    |
|----------------------------|------------------------------------|
| <u>01</u> Pharmacy         | <u>03</u> School                   |
| <u>04</u> Homeless Shelter | <u>11</u> Office                   |
| <u>12</u> Home             | <u>13</u> Assisted Living Facility |
| <u>14</u> Group Home       | <u>99</u> Other                    |

**16. CPT/HCPCS Code:** Enter the CPT or HCPCS code for services billed as shown on the Authorization Letter and/or Compensation page of your contract for the type of service being billed on each line. If you are unsure of which code to use, please contact the Provider Help Desk.

**17. Modifier:** Enter the modifier for the service CPT or HCPCS codes as shown on the Authorization Letter and/or Compensation page of the contract for the type of service being billed on each line. If there is no modifier for the type of service being billed, leave blank.

18. Service Description: Enter the Service Description for the CPT or HCPCS codes for services billed as shown on the Authorization Letter and/or Compensation page of your contract for the type of service being billed on each line.
19. Units Billed: Enter number of whole units that correspond to the CPT or HCPCS code being billed as shown on the Authorization Letter and/or Compensation page of the contract for the type of service being billed on each line.
20. (\$) Rate per Unit: Enter the rate that corresponds with the code and units being billed as shown on the Compensation page of the contract for type of service being billed on each line. Always include cents when entering dollar amounts (e.g. 14.75 or 14.00).
21. (\$) Total Charges: Multiply “Units Billed” (column 19) and “Rate per Unit” (column 20) and enter the total in “Total Charges” (column 21) for each line. Always include cents when entering dollar amounts (e.g. 14.75 or 14.00).
22. Total Charges: Add all numbers in column 21 and enter the total billed amount to be processed using two decimal points (e.g. 250.75).
23. Authorized Signature: Signature of person authorizing accuracy of claim.  
**Print Name**: Clearly print the name of the person signing the claim.  
**Date**: Enter the date the claim was signed by the authorized person.
24. Mail completed claim form to: **Care Wisconsin  
P.O. Box 849  
Buckeystown, MD 21717**

**Submitting a CORRECTED claim for a claim that has been PARTIALLY denied:**

- For a **partially** denied claim where the information submitted was incorrect, complete a new claim form with accurate information using the Care Wisconsin General Services Claim Form Instructions. The new claim form must include ALL services billed on the original submission, not just those services that are being changed
- Indicate “Corrected Claim” in bold letters at the top of the form and include the claim number from the original claim, if possible.
- Staple a cover sheet on the General Services Claim Form stating “Attached is a corrected claim form for consideration.” Each corrected claim form requires its own coversheet.
- Mail corrected form to: **Care Wisconsin  
P.O. Box 849  
Buckeystown, MD 21717**

**Re-submitting a claim that has been COMPLETELY denied:**

For a **completely** denied claim where the information submitted was incorrect, prepare the claim with the correct information on a new claim form and submit the claim form in the normal way.

**If your claim was partially or completely denied for other than incorrect information:**

First, please contact the Provider Help Desk if you need clarification on the denial. If after checking with the help desk, you still believe that the denial or underpayment was in error, you may send a request for an appeal. You must submit your appeal in writing within 60 calendar days of the denial by sending a letter marked “Appeal” with specific information to:

**Care Wisconsin  
Attn: Claims Appeals  
P.O. Box 14017  
Madison, WI 53708-0017**