CARE WISCONSIN CLAIM REFUND

Providers may send this completed form to the following address:

Care Wisconsin
ATTN: Refunds
1617 Sherman Ave
Madison, WI 53704

INSTRUCTIONS: Type or print clearly.

SECTION I – PROVIDER INFORMATION

Name – Provider Filing Refund	Telephone Number – Provider Filing Refund
Address – Provider Filing Refund (Street, City, State, ZIP code)	Name and Telephone Number – Contact Person

SECTION II – MEMBER INFORMATION

Member Name	Member Identification Number	Date of Service

SECTION III – CLAIM INFORMATION OR ATTACH REMITTANCE ADVICE

Claim Number			Check Issue Date	Check Number
Dates of Service From	To	Procedure Code or National Drug Code or Revenue Code	Billed Amount	Refund Amount
			Refund Total :	$ 0

SECTION IV – REFUND INFORMATION

Reason for Refund (Check One)

- ◯ Medicare paid
- ◯ Overpayment
- ◯ Other commercial health or dental insurance payment (please include EOB)
- ◯ Not our patient
- ◯ Wrong date of service
- ◯ Duplicate payment by Care Wisconsin
- ◯ Billing error
- ◯ Charges voided
- ◯ Item returned
- ☐ Other/Comments: _____

SECTION IV - SIGNATURE

This information is accurate to the best of my knowledge.

SIGNATURE – Provider	Date Signed