WPS GHA PART B
INDIANA DEVELOPMENT RESOLUTION

Please indicate which type of documentation you are returning

☐ High Dollar Development Resolution

☐ General Development Resolution

To: Medicare Claims Department
Fax Number: 608-224-3505

# of pages_____ (including cover sheet) Date: _____

ALL REQUESTED INFORMATION ON THIS FORM MUST BE COMPLETED. INCOMPLETE FORMS MAY BE RETURNED TO THE SENDER.

Provider Information:

Provider Name: _____ NPI: _____

Contact Name: _____ Phone Number: _____

Claim Information:

Beneficiary Name: _____ *Claim ICN: _____

Documentation Information:
Requested High Dollar Information Attached: ◯ Yes ◯ No
RX#, Drug Name, Drug NDC#, # of Vials, # of Unit/MCG per Vial, Operative Notes, Invoices, Physician Notes, Package Inserts, etc.
Requested General Development Information Attached: ◯ Yes ◯ No
Operative Notes, Invoices, Run Sheets, etc.

Additional Information:

***ONE DEVELOPMENT RESOLUTION FORM IS REQUIRED FOR EACH ICN.**