



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.**

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