



**WPS GHA PART B  
MISSOURI DEVELOPMENT RESOLUTION**

**Please indicate which type of documentation you are returning**

High Dollar Development Resolution

General Development Resolution

To: Medicare Claims Department

Fax Number: 608-223-7546

# 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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