group health Cooperative of eau claire

Medical Claim Notes Form

Member Information

Member Name (please print)	Date of Birth	Member ID#
Claim Date(s) of Service	Billed Amount(s)	

Provider Information

Provider		
Contact Name	Phone	Fax
Address		

Type of Documentation Attached

Please select one of the following:

- ☐ Notes to Support
- ☐ Refund dispute
- ☐ Dispute Payment Amount
- ☐ Coding
- ☐ Other Insurance/Liability
- ☐ Non-covered
- ☐ Other (explain below)

Number of pages including cover sheet:

Additional information

Please include the following:

- ☐ Copy of claim
- ☐ Check here if you are enclosing a **CORRECTED CLAIM**
- ☐ Supporting documentation:
  - Clinical notes
  - Proof of timely filing
  - Other information to support your request

PLEASE FAX COMPLETED FORM TO: Group Health Cooperative of Eau Claire **Fax:** 715.836.7683

OR MAIL TO: "Provider Services" PO Box 3217, Eau Claire, WI 54702