group health Cooperative of eau claire

Provider Appeal Form

****If you are submitting a timely corrected claim, you do not need to send this 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		Date Submitted

Type of Appeal

Please select one of the following:

- ☐ Timely Filing
- ☐ Coding
- ☐ Dispute Payment Amount
- ☐ Non-covered
- ☐ Refund dispute
- ☐ Other (explain below)
- ☐ Other Insurance/Liability
- ☐ Lack of Authorization/Referral

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: "Attention Appeals" PO Box 3217, Eau Claire, WI 54702