



Provider Appeal Form

**If you are submitting a timely corrected claim, do not use this form.
Please fax your information to the Claims Department at 715-598-7525.**

Provider Information			
Provider Name (please print)		Address	
Contact Name	Phone	Fax	
Contact Email			Date Submitted
Member Information			
Member Name (please print)		Date of Birth	Member ID#
Date(s) of Service	Denied Service Codes	Denied Code Description	
Billed Amount(s)	Claim Number (ICN)		
<input type="checkbox"/> Medicaid Member <input type="checkbox"/> Medicare Advantage Member <input type="checkbox"/> Commercial Member <input type="checkbox"/> ETF Member			
Submission Type			
<input type="checkbox"/> First Request <input type="checkbox"/> Subsequent Request (New Documentation)			
Appeal Reason			
Please select one of the following:			
<input type="checkbox"/> Timely Filing	<input type="checkbox"/> Non-covered	<input type="checkbox"/> Other (explain below)	
<input type="checkbox"/> Coding Review: Must include medical records and correct coding rationale.	<input type="checkbox"/> Dispute Payment Amount		
<input type="checkbox"/> Other Insurance/Liability	<input type="checkbox"/> Refund Dispute		
	<input type="checkbox"/> Lack of Prior Authorization		
Please include any of the following:			
<input type="checkbox"/> Copy of Claim		<input type="checkbox"/> For Non-contracted Medicare Providers: Waiver of Liability Form	
<input type="checkbox"/> Supporting documentation: <ul style="list-style-type: none"> • Clinical notes • Proof of timely filing • Other information to support your request 			

PLEASE FAX COMPLETED FORM TO: Group Health Cooperative of Eau Claire, Attn: Appeals - Fax: 715.598.7538
OR MAIL TO: Group Health Cooperative of Eau Claire, Attn: Appeals, PO Box 3217, Eau Claire, WI 54702