WISCONSIN MEDICAID AND BADGERCARE PLUS
MANAGED CARE PROGRAM PROVIDER APPEAL

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Personally identifiable information about providers is used for purposes directly related to program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the services. The use of this form is voluntary.

Providers may send this completed form and other written complaints to the following address:

ForwardHealth
Managed Care Appeals
PO Box 6470
Madison WI 53716-0470

INSTRUCTIONS: Type or print clearly.

SECTION I — PROVIDER INFORMATION

Name — Provider Filing Appeal	Telephone Number — Provider Filing Appeal	Name — HMO / SSI MCO Involved
Address — Provider Filing Appeal (Street, City, State, ZIP Code)		Name and Telephone Number — Contact Person

SECTION II — ENROLLEE INFORMATION

Name — Medicaid HMO / SSI MCO Enrollee	Member Identification Number	Date of Service

SECTION III — DESCRIPTION OF PROBLEM

Describe the problem in detail. Use additional paper, if necessary. Attach copies of any supporting documentation relevant to the problem.

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SECTION III — DESCRIPTION OF PROBLEM (Continued)

Insert date the appeal was sent to HMO / SSI MCO or claim reconsideration was requested.	Insert date the appeal / reconsideration request was denied by HMO / SSI MCO.

What response was received from the HMO / SSI MCO? Attach a photocopy of any relevant correspondence.

What does the provider consider to be a fair resolution of this matter?

SECTION IV — SIGNATURE

This information is accurate to the best of my knowledge. A copy of this information may be forwarded to the Medicaid HMO/SSI MCO involved.

SIGNATURE — Provider	Date Signed