

APPENDIX 2 – PROVIDER APPEAL FORM



A Program of Partnership Health Plan, Inc.

2240 EastRidge Center
Eau Claire, WI 54701
715/838-2900 • 800/842-1814
Fax: 715/838-2910

Provider Name (print) _____
Practice Name _____
Patient Name _____
Medical history number _____ Date of birth _____
Date(s) of service _____
CPT/HCPCS code(s) _____
Total charge(s) _____

Explain in detail why you feel Partnership Health Plan, Inc. should review and reconsider its decision on the charge(s) in question.

Indicate in the medical record where it supports your appeal if applicable.

Please submit any additional information that may apply to your appeal. Also, attach a copy of your claim or statement.

Signature

Date

Telephone Number

Return to:
Community Health Partnership
Attention: Grievance and Appeals Coordinator
2240 EastRidge Center
Eau Claire, WI 54701
Telephone: 715-838-2900 or (800) 842-1814
Fax: 715-838-2910

If you have any questions or want an expedited appeal, please contact the Grievance and Appeals Coordinator at 715-838-2900. For Voice/TTY services, call toll free at 1-800-842-1814. The hours of the Customer Service Department are 8:00 AM – 4:30 PM, Monday through Friday.