Appeal Form

Important Notes:

- The form must be completed in full. Requests received without this form or with an incomplete form will be returned
- Complete one Appeal form for each member/appeal reason
- You have 60 days from claim determination to submit an appeal request
- Include a copy of claim and additional supporting documentation.

Mail To:

Community Care, Inc.
Attn: Claims Department - Appeals
P.O. Box 923
Brookfield, WI 53008-0923

Fax To:

Attn: Claims Department - Appeals
(414) 385-6615

Corrected Claims, Adjustments, and Review/Reconsiderations Requests:

Send corrected claims, adjustments, and review/reconsideration using the appropriate form(s), which can be found on our website: https://communitycareinc.org/for-providers/frequently-used-forms
Corrected claims can also be submitted electronically with the appropriate resubmission type.

Provider Information

Contact Name:

Phone Number:

Contact E-mail:

Provider Name:

Address (City, St, and Zip):

Tax Identification Number (TIN):

Billing NPI Number:

Member Information

Member/Patient Name:

Member/Patient Date of Birth:

Member Account Number:

Appeal Form *(continued)*

Claim Information

DCN(s)	Date(s) of Service:	Total Billed Amount:

Reason for Appeal: *check box for appeal reason*:

☐ Authorization Denial *(please include copy of prior authorization)*
☐ Non-Covered Service
☐ Underpayment
☐ Coding or Modifier Denial
☐ Timely Filing Denial *(please include proof of timely filing)*
☐ Non-Contracted Provider
☐ Other:

Additional Information:

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