CARE WISCONSIN PROVIDER APPEAL

Providers may send this completed form to the following address:

Care Wisconsin
ATTN: Claims Appeals
1617 Sherman Ave
Madison, WI 53704

INSTRUCTIONS: Type or print clearly.

SECTION I – PROVIDER INFORMATION

Name – Provider Filing Appeal	Telephone Number – Provider Filing Appeal
Address – Provider Filing Appeal (Street, City, State, ZIP code)	Name and Telephone Number – Contact Person

SECTION II – MEMBER INFORMATION

Member Name	Member Identification Number	Date of Service

SECTION III – DESCRIPTION OF PROBLEM
Describe the problem in detail, and any previous efforts made to resolve the claim(s). Use additional paper if necessary. Attach copies of any supporting documentation relevant to the problem.

SECTION IV – SIGNATURE

This information is accurate to the best of my knowledge.

SIGNATURE – Provider	Date Signed