My Choice Wisconsin BadgerCare Plus Claims Appeal Form

Providers may send this completed form to the following address:

My Choice Wisconsin Health Plan
ATTN: Provider Appeals Department
P.O. Box 70491
Milwaukee, WI 53207
FAX: 414-448-6710

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 AND CLAIM INFORMATION		
Member Name	Member Identification Number	Date of Service
Claim Number	Paid Amount	Paid Date

SECTION III – DESCRIPTION OF PROBLEM

Describe the problem in detail, and any previous efforts made to resolve the claims. 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