

PROVIDER APPEAL FORM

Providers should send this completed form to the appropriate address for the member's TPA. For Family Care, SSI and Partnership members, please use the TriZetto/WPS address. For BadgerCare members, please use the Trilogy/SMG address. If you are unsure which address to use, you may call Customer Service at 800-963-0035.

TriZetto/WPS Claims Appeals:

Attn: Claims Appeals
1617 Sherman Ave
Madison, WI 53704

Trilogy/SMG Appeals:

Provider Appeals Dept.
P.O. Box 70491
Milwaukee, WI 53207

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(s) of Service
Claim Number(s)	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	

INSTRUCTIONS: Type or print clearly.