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.