Group Health Cooperative
of South Central Wisconsin

MEMBER APPEAL FORM

Please complete the entire form before submitting.

Member Last Name (as printed on membership card):	**Member First Name** (as printed on membership card):
GHC-SCW Member ID Number (six digits):	**Mailing Address** (of person requesting appeal):
Phone Number Please provide the best number to contact you between 7 a.m. and 5 p.m. If there is a change in your phone number, please contact the GHC-SCW Member Services Department at (608) 828-4853 or (800) 605-4327. **Primary Phone:**	**Email Address:** **Consent to use email:** **Yes** **No**

Have the service(s) being appealed already occurred? **Yes** **No**

This request is in regards to a member denial for coverage of the following service(s):

(Please tell us in one sentence what you are appealing. For example: *I am appealing the denial of referral 1234567 for coverage of [information from referral letter] or for claim number 12345678 for date of service 01/02/03.* Your reason for your appeal and details need to be entered on page 2 of this form.)

If this appeal is for services already received and denied, please provide dates of services and cost of services below.

Date of Service	Billed Amount	Patient Responsibility

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Please add any additional information which supports your belief that GHC-SCW should authorize payment for these services.
(If you need additional space please feel free to attach a document.)

You will need to contact your providers and acquire copies of all medical records that apply to your appeal.
Include them with this document.
GHC-SCW can only access records from GHC-SCW-owned clinics
(Capitol, DeForest, East, Hatchery Hill, Madison College and Sauk Trails Clinics).

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Release of Information for Appeal Process

I understand that GHC-SCW will discuss information and disclose documents to the investigation and resolution of my appeal with internal and external staff or individuals as deemed necessary.

Print Full Name as Appears on Membership Card: _____

Member's Signature: _____ **Date:** _____

If you are filing this appeal on behalf of the member you must include this signed authorization from the member.

Authorization for a representative to act on your behalf in the appeal process

I _____ give _____ authorization to act on my behalf in the appeals process. All of my appeal/medical information may be shared with my representative.

Member's Signature: _____ **Date:** _____

Authorized Representative's Name:

Relationship to Member:

Authorized Representative's Address:

Phone Number
Please provide the best number to contact you between 7 a.m. and 5 p.m. If there is a change in your phone number, please contact the GHC-SCW Member Services Department at (608) 828-4853 or (800) 605-4327.

Primary Phone:

Email Address:

Consent to use email: **Yes** **No**

Please mail this completed form and all appropriate documentation to:

GHC-SCW Member Appeals
PO Box 44971
Madison WI 53744-4971

You may also fax this information to:

Fax: (608) 662-4980 Attention: GHC-SCW Member Appeals