Group Health Cooperative
of South Central Wisconsin

Provider Appeal Form

Member Last Name *(as printed on membership card)*	Member First Name *(as printed on membership card)*

GHC-SCW Member ID # *(six digits)*	Group Number	Provider Name *(person filing the appeal)*

Provider Address

Phone Number	Fax Number

I am the provider of the services being appealed: Yes No

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

The service(s) being appealed have already occurred? Yes No

This request is in regard to coverage of the following claims:

Why do you think GHC-SCW should authorize these services? Check all that apply.

____ Additional information is being provided that was not previously available for review.

____ There are no GHC-SCW providers who can provide this service.

____ I was led to believe this service was covered in full or at a different cost share.

____ Member failed to provide documentation showing they had coverage with GHC-SCW at the time services were provided preventing our office from getting required prior authorization.

____ We were not aware that these services required prior authorization and believe they are medically necessary and should be covered retrospectively.

____ Other ____

Please include all medical records supporting this appeal.

Please document in detail why you believe the denial should be overturned *(if you need additional space please feel free to attach document)*.

Please mail this completed form and all appropriate documentation to:

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

You may also fax this information to:

Fax: (608) 828-4856 Attention: GHC-SCW Provider Appeals