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.)

Do you have a GHC MyChart account? Yes ○ No ○

If yes, we will send appeals communication through your GHC MyChart account.

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

If additional lines are needed, please use the next page.

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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

Helpful tips when filing an appeal:

All appeal documentation for review must be submitted on hard copy (a printed version on paper).

The information on page 1 of the appeal form is for the person who the services/claims are for. [Do not put the subscriber's name here if the appeal is for a family member]

Page 2 of the appeal is where you will present your case. Please be concise and comprehensive with your presentation. You are responsible for showing that your plan benefits have been denied in error. The Appeal Committee members who will be reviewing and making the decision on your appeal are not aware of your situation and have not been involved in the decision making prior to your review.

If you are appealing a situation related to a denied referral and you went forward with the services. You will need to submit copies of the medical records, your itemized statement from the provider containing the diagnosis, procedure codes and charges and a copy of your receipt.

You are responsible to gather all medical records related to your appeal. Your Member Appeal Representative only has access to records at the GHC-SCW owned clinics which include the Capitol, Sauk Trails, East, Deforest, Hatchery Hills and Madison Community College Clinics. All medical records from the other clinics, you must gather and submit with your appeal form. Please be sure that you have gathered all documentation and submit it in full.

Page 3 of the appeal form must be completed for us to be able to process your appeal. If you are appealing for a child under the age of 12, the parent/legal guardian will sign where the Member's signature is required. If your child is 12 years or over, they must sign the Authorization and the Authorization for a representative. Anyone over 17 years of age is required to provide written authorization for the appeal and for a representative if they so desire.

If you are faxing appeal information, please call Member Services at 608-828-4853 shortly after you have faxed the documentation so that we are alerted and can be looking for this documentation. Let us know how many pages to expect and provide us with a call back number so that we can alert you back if your fax submission does not come through.

Please do not submit this page with your appeal form.