

Reconsideration / Formal Appeal Form

Today's Date

You have the right to appeal. Should you wish to dispute a claim denial or claim payment amount, you may request an appeal by submitting a Reconsideration/Formal Appeal Form. If submitted, it must be received within 60 days of the claim determination being disputed for Medicaid and 65 days for Medicare. Please ensure this form is filled out in its entirety along with copies of all supporting documentation and mail to address below.

Mail To: iCare\Appeals Dept.
1555 N. RiverCenter Dr
Suite 206
Milwaukee, WI 53212

Note: Medicare Contracted Providers are unable to submit a Formal Appeal. Please complete a Review/Reopening Form instead.

Type of Provider (select one)

Medicare Non-Contracted
 Medicaid Non-Contracted
 Medicaid Contracted

Checklist of items required (If any item from the list is not included, submission may be delayed or dismissed)

Waiver of Liability (WOL) only if Medicare Non-Contracted
 Explanation of Payment (EOP)
 Copy of Claim or Supporting Documentation

Provider Name: NPI: TIN:

Billing Address:

Contact Name: Contact Phone #: Fax #:

Contact Address:

Member First Name: Member Last Name: iCare Member ID#: Member DOB:

Claim#: From Date of Service: To Date of Service: Billed Amount:

Reason given for denial (check all that apply)

Authorization Denials
 Not Prior Authorized
 Benefit Denials
 Incidental / Mutually Exclusive/ Mutually Unlikely
 Other

Timely Filing
 Out of Network
 Invalid Code

Reason For Request

Signature:

Date: