# DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN

Division of Medicaid Services Wis. Stat. § 49.45

F-12022 (02/2020)

## WISCONSIN MEDICAID AND BADGERCARE PLUS

**MANAGED CARE PROGRAM PROVIDER APPEAL**

**INSTRUCTIONS:** Type or print clearly. Refer to the Managed Care Program Provider Appeal Instructions, F‑12022A, for more information.

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| SECTION I – PROVIDER INFORMATION |
| 1. Name – Provider Filing Appeal      | 2. Phone Number – Provider Filing Appeal      |
| 3. Address – Provider Filing Appeal (Street, City, State, Zip Code)      |
| 4. Secure Email Address – Provider      |
| 5. Does the provider have a contractual arrangement with the HMO? [ ]  Yes [ ]  No |
| 6. Name – Contact Person      | 7. Phone Number – Contact Person      |
| 8. Name – BadgerCare Plus / Medicaid SSI HMO Involved      |
| SECTION II – MEMBER INFORMATION |
| 9. Name – BadgerCare Plus / Medicaid SSI HMO Member      |
| 10. Member ID Number      | 11. Date(s) of Service      |
| SECTION III – DESCRIPTION OF PROBLEM |
| 12. Describe the problem in detail. Attach additional pages if necessary. Attach copies of all required documents and any other supporting documentation relevant to the problem.      |
| 13. Enter the date the appeal was sent to the BadgerCare Plus / Medicaid SSI HMO. An appeal to the HMO is required before submitting an appeal to ForwardHealth. Attach a copy of the appeal to the HMO.      |
| 14. Enter the date the appeal was denied by the BadgerCare Plus / Medicaid SSI HMO. Attach a copy of the HMO denial.      |
| 15. What response was received from the BadgerCare Plus / Medicaid SSI HMO? Attach a copy of any relevant correspondence.      |
| 16. Describe what the provider considers to be a fair resolution of this matter.      |
| SECTION IV – SIGNATURE |
| **This information is accurate to the best of my knowledge. I have reviewed the Managed Care Program Provider Appeal Instructions and assure that all necessary documents are attached. A copy of this information may be forwarded to the BadgerCare Plus/Medicaid SSI HMO involved.** |
| 17. **SIGNATURE** – Provider | 18. Date Signed |