## WISCONSIN MEDICAID AND BADGERCARE PLUS
# MANAGED CARE PROGRAM PROVIDER APPEAL

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

**SECTION I – PROVIDER INFORMATION**

| 1. Name – Provider Filing Appeal | 2. Telephone Number – Provider Filing Appeal |
|---|---|
| 3. Address – Provider Filing Appeal (Street, City, State, ZIP Code) | |
| 4. Provider-Secure Email Address | 5. The provider has a contractual arrangement with the HMO. ☐ Yes ☐ No |
| 6. Name – Contact Person | 7. Telephone 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. Use additional paper, if necessary. Attach copies of any supporting documentation relevant to the problem.

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**SECTION III – DESCRIPTION OF PROBLEM (Continued)**

13. Insert the date the appeal was sent to the BadgerCare Plus / Medicaid SSI HMO.

14. Insert the date the appeal was denied by the BadgerCare Plus / Medicaid SSI HMO.

15. What response was received from the BadgerCare Plus / Medicaid SSI HMO? Attach a photocopy 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 Completion 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.**

| **SIGNATURE** – Provider | Date Signed |
|---|---|
| | |

Reset Form