



# 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. 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: