

**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.

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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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
