Provider Appeal / Claim Review Request Form

Please send one form and supporting documentation per claim review request to:
Together with Children's Community Health Plan
Attn: Appeals Department
P.O. Box 1997, MS 6280
Milwaukee, WI 53201

Date: _____

SECTION 1: Provider Contact Information

Provider Name	Tax ID
Contact Name	Email Address
Phone Number (Area Code) XXX-XXXX	Mailing address for correspondence (Include City, State, and Zip

SECTION 2: Member Information

Name (First, Middle Initial, Last)	Member number (On Member ID Card)
Claim Number	Date of Service

Comments:
