WPS Provider Appeals Form

IMPORTANT: Before proceeding, please note:

- Pre-service appeals, including expedited, should follow the member appeals process.
- This form should only be used for post-service denials based on:
  - Non-compliance with prior authorization requirements
  - Not medically necessary or experimental/investigational/unproven
- This form must be completed in full. Requests submitted without a completed form or submitted with an incomplete form will be returned.
- You have up to 60 days from date of denial to submit an appeal request.

REQUESTOR INFORMATION *(Where appeal correspondence should be directed)*

Name of Requester:			Date Prepared:
Physician/Facility Name:			
Phone Number:	Ext:	Fax:	
Mailing Address:			
City:		State:	ZIP:

CLAIM INFORMATION

Claim Number(s):	Date(s) of Service:
Procedure/HCPCS Code(s):	Description(s):

CUSTOMER INFORMATION

Customer Last Name:	Customer First Name:
Customer Date of Birth:	Customer Number:

APPEAL TYPE AND REASON FOR APPEAL

Appeal Type:
- ☐ Non-compliance with prior authorization requirements
- ☐ Not medically necessary or experimental/investigational/unproven

State the reason for the appeal and attach supporting documentation.
NOTE: If claim was denied for non-compliance with prior authorization requirements and prior authorization was obtained, provide the prior authorization number. If claim was denied for non-compliance with prior authorization requirements and prior authorization was not obtained, state the reason why authorization was not obtained.

MAILING ADDRESS

Mail or fax completed form and supporting documentation to:

Fax: 608-327-6337
Mail: WPS Provider Appeals, P.O. Box 7062, Madison, WI 53707-7062

WPS
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