Claim Appeal Submission Form

If you have questions regarding a partial payment or denial that cannot be resolved by the WPS/Family Care Contact Center, please contact Inclusa at providerclaimappealandaudit@inclusa.org or 1-888-544-9353, option 8. (Note: If you send email and are including protected member information, you must use secure email). Your situation will be reviewed, and you will be advised of your options. If you have a dispute and it cannot be resolved with Inclusa Customer Support staff, you will be instructed to file a formal appeal to the Inclusa Provider Appeals Department.

If you wish to file a formal appeal, you must submit this form and attach a copy of the WPS Provider Remittance Advice (PRA), a copy of the Explanation of Medicare Benefit (EOMB) or other insurance PRA if applicable, and all other documentation to support your appeal. Please reference "Claims Appeal Process for Inclusa" for documentation needed. Mail the form to the address listed below.

Provider (Business) Name			Date(s) of Service
Member Name	Date of Birth	Procedure Code(s)	Appeal Amount
Reason your claim merits reconsideration (please provide detailed explanation):			
Signature		Date Signed	
Contact Information For Person Submitting Form			
Name	Phone	Email	
Address	City	State	Zip

This form must be submitted within 60 calendar days of the initial WPS denial or partial payment. Please fill out this form and submit to Inclusa, using one of the following methods:

Email: providerclaimappealandaudit@inclusa.org
Fax: (608)-785-5335
Mail: Inclusa, Inc.; 2615 East Avenue South; Suite 103; La Crosse, WI 54601

If Inclusa fails to respond to the appeal within 45 calendar days or if you are not satisfied with Inclusa's response to the reconsideration request, you have the right to appeal to the Department of Health Services (DHS). All appeals to DHS must be submitted in writing within 60 days of Inclusa's final decision or failure to respond. The submission must be clearly marked as an "Appeal" and indicate provider name, address, date of service, date of billing, date of rejection, and reason(s) for the request for reconsideration or appeal. DHS appeals should be sent to the Provider Appeals Investigator – Division of Medicaid Services using one of the following methods:

Fax: (608) 266-5629
Mail: Provider Appeals Investigator/Division of Medicaid Services
1 West Wilson Street, Room 518
PO Box 309
Madison, WI 53701-0309

Inclusa Use Only
GSR Region:
Respond by Date:
Appeal #:
Vendor #:
Provider Name: