**Claim Appeal Submission Form**

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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 [providerclaimappeal@inclusa.org](mailto:providerclaimappeal@inclusa.org) or 1-888-544-9353, option 8.

If Inclusa is unable to resolve, you will be advised of your right to file an appeal with Inclusa.

If you wish to file a formal appeal, please complete, and submit this form and attach a copy of the WPS Provider Remittance Advice (PRA), copies of primary payor’s Explanation of Medical Benefits (EOMB), if applicable, and any other documentation to support your appeal.

For more information, please reference the “Provider Appeal Rights Under Family Care” on our website: [www.Inclusa.org](http://www.Inclusa.org) .

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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:** [providerclaimappeal@inclusa.org](mailto:providerclaimappealandaudit@inclusa.org)

**Fax:** (866) 880-0551

**Mail:** 2801 Hoover Rd, Unit 3, Stevens Point, WI 54481

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 include the following:

* Member’s name and date of birth
* A specific explanation of the payment amount or a specific reason for nonpayment, partial payment, or denial
* Contain the provider’s name, provider’s address, date of service, date of billing, procedure code, date of rejection, and reason(s) the claim merits reconsideration for each appeal
* Include the appeal denial letter from the MCO

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

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09/06/2023