CHORUS COMMUNITY HEALTH PLANS

PROVIDER APPEAL / CLAIM REVIEW REQUEST FORM

Please send one form and supporting documentation per claim review request to:
Chorus Community Health Plans
P.O. Box 56099
Madison, WI 53705

DATE:____/____/_________

SECTION 1: PROVIDER CONTACT INFORMATION

PROVIDER NAME	TAX ID NUMBER
CONTACT NAME	EMAIL ADDRESS
PHONE NUMBER (AREA CODE) XXX-XXXX	MALING ADDRESS FOR CORRESPONDENCE (INCLUDE CITY, STATE, AND ZIP)

SECTION 2: MEMBER INFORMATION

NAME (FIRST, MIDDLE INITIAL, LAST)

MEMBER NUMBER (ON MEMBER ID CARD)	PATIENT ACCOUNT NUMBER
CLAIM NUMBER	DATE OF SERVICE (MMDDYYYY)

SECTION 3: CODING CORRECTION / REVIEW REQUEST (USE TO APPEAL A DENIED CHARGE)

Check the box with the topic that best describes the denial received and submit a corrected claim if appropriate. When requesting a review of a denied code, please include a brief explanatory statement and supporting documentation.

- ○ Code bundling (ANSI 234/ M15, M20/16, 97, 150,231)
- ○ New patient visit denial (ANSI B16)
- ○ Place-of-service denial (ANSI 5)
- ○ Noncovered procedure denial (ANSI 96)
- ○ Other:
- ○ Maximum units / frequency of service (ANSI 151)
- ○ Invalid / Missing / Inappropriate modifier (ANSI 4)
- ○ Diagnosis denial (ANSI 11,9)
- ○ Duplicate denial (ANSI 18)
- ○ Unlisted / Miscellaneous code denial (ANSI 16 / N350, 133)

Comments:

SECTION 4: OTHER CORRECTION / REVIEW REQUEST

- ○ Proof of authorized service (include authorization number___________________________)
- ○ Coordination of benefits
- ○ Timely filing
- ○ First Review
- ○ Subsequent review (Submission of new documentation required)