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 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
Patient Account Number	Date of Service

SECTION 3: Comments
