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
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

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