1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

1-877-509-4979
TTY 711

Formal Provider Appeal

For formal appeals only. Do not use for corrected claims or reconsideration requests.

Provider name (print) _____

Practice name _____

Select one: ☐ Pre-service ☐ Post-service

Patient name (print)_____ Date of Birth (mm/dd/yyyy) _____ /_____ /_____

Subscriber ID_____

Service date(s) _____ Claim number (ICN) _____

Remit/Statement date (m/d/y) _____ /_____ /_____ Date of billing (m/d/y) _____ /_____ /_____

CPT/HCPCS code(s) _____ Is the denial member's responsibility: ☐ Yes ☐ No

Total billed charges _____

Explain in detail why you feel Sanford Health Plan should review and reconsider our decision on the charge(s) in question.

Please submit any additional information that may apply to your formal appeal. If medical records are submitted, indicate in the medical record where it supports your appeal. Also attach a copy of your claim or statement.

Please provide information for the individual submitting the appeal.

NOTE: This will be the address we mail your appeal decision letter to.

Name (print) _____

Address _____

City _____ State _____ ZIP _____

Telephone number _____

Date submitted (m/d/y) _____ /_____ /_____

Completed appeals should be returned to:

Sanford Health Plan
Attn: Provider Appeals
P.O. Box 8000
Marshfield, WI 54449-8000

Fax: 715-221-9650
SHP-MA-ProviderAppeals@sanfordhealth.org