



1515 North Saint Joseph Avenue  
P.O. Box 8000  
Marshfield, WI 54449-8000  
1-877-492-5189  
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:

Great Plains Medicare Advantage  
Attn: Provider Appeals  
P.O. Box 8000  
Marshfield, WI 54449-8000

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