



Contracted Participating (PAR) Provider Appeal/Reconsideration Form

(PROVIDERS MUST FILE AN APPEAL WITHIN 180 DAYS FROM DATE ON WME ORIGINAL REMITTANCE ADVICE)

Claim and/or Medical Appeals/Reconsiderations may be filed with Windsor Medicare Extra to challenge any determination a contracted participating Provider feels was made in error. Print or type this form in completion, attach appropriate documentation and mail to:

Windsor Medicare Extra
Attention: Appeals Coordinator
7100 Commerce Way, Suite 285
Brentwood, TN 37027

DATE: _____ PROVIDER NAME: _____

ADDRESS (Street, City, Zip): _____

Tax ID: _____ PHONE #:(____) _____ FAX #:(____) _____

CONTACT NAME: _____ EMAIL: _____

CLAIM INFORMATION:

PATIENT NAME: _____

PATIENT ID #: WX _____ DATE OF SERVICE: _____

CLAIM # _____ BILLED AMOUNT: \$ _____

REQUEST FOR REVIEW: (Indicate the reason(s) this claim should be reconsidered)

- The following attachments are required, if applicable:
1. Supporting documents (operative reports, med records, chart notes, Medicare EOB, etc.)
 2. Claim form
 3. WME original denial remittance advice
 4. Proof of eligibility verification or explanation of why eligibility verification was not obtained

INCOMPLETE APPEAL/RECONSIDERATION REQUESTS WILL NOT BE CONSIDERED

For Windsor Medicare Extra Use Only	
Date of Receipt:	_____
Decision:	_____
Date of Decision:	_____
Adjusted Claim #	_____