



## 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 fax or mail to:

**Fax Number: (615) 782-7971**  
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:**

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 (if applicable to reason for reconsideration)

**INCOMPLETE APPEAL/RECONSIDERATION REQUESTS WILL NOT BE CONSIDERED**

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