



NON-CONTRACTED PROVIDER APPEAL FORM

TO:	Windsor Health Plan, Inc. Attention: Non-Contracted Provider Appeals 7100 Commerce Way, Suite 285 Brentwood, TN 37027
FROM:	Provider: _____
	Contact: _____
	Telephone No.: (_____) _____
	Fax No.: (_____) _____
	Address: _____
	_____ Street Number and Name
	_____ City _____ State _____ Zip Code

Member Name: _____

Member ID No.: _____

Date(s) of Service: _____

Reason(s) for Appeal: (Attach additional sheet(s) if needed.)

Signature

Date

1. Requests for appeal must be filed within **60 calendar days** of the original "Explanation of Payment" denying payment of the claim(s).
2. A "Waiver of Liability Statement" must be completed in order for Windsor Health Plan to process the appeal.
3. Please include medical records related to the claim(s) being appealed and any other supporting documentation.