COMMON GROUND
HEALTHCARE COOPERATIVE

Claim Reconsideration

Date: _____

To: Common Ground Healthcare Cooperative
ATTN: Claims Department
PO Box 1630
Brookfield, WI 53008-1630

Contact Name: _____

Company: _____

Telephone: _____

E-mail: _____

CGHC Member ID: Patient _____

Name: _____

Date of Birth: _____

Date of Service: _____

Submitted Amount: _____

Claim Number*: _____

Rendering Provider Name: _____

Provider TIN: _____

Reconsideration related to: Select from dropdown

Comments:

*For multiple claims related to same member and reconsideration type, please attach a spreadsheet with columns outlining fields above for each claim number.

Note: This form is not intended for: the submission of corrected claims, appeals of medical necessity decisions obtained through the prior authorization process, retro authorization submission, or submission of records for lack of information denials related to the prior authorization process.