COMMON GROUND
HEALTHCARE COOPERATIVE

CLAIM RECONSIDERATION REQUEST

This form is not intended for:

- Submission of corrected claims
- Appeals of medical necessity decisions obtained through the prior authorization process
- Retro-authorization submission
- Submission of records for lack of information denials related to the prior authorization process

Request Date:

Provider Information		
Contact Person's Name:		Telephone:
Company Name:		Email:
Mailing Address:		
City, State Zip:		
Patient Information		
Patient Name:		Date of Birth:
CGHC Member ID#		
Claim Information		
Date of Service:		Submitted Amount:
Claim Number*:		*For multiple claims related to same member and reconsideration type, please attach a spreadsheet with columns outlining fields above for each claim number.
Rendering Provider Name:		Provider TIN:
Reconsideration related to (check appropriate reason below)		
☐ Code Edit Dispute ☐ Contract Benefit ☐ EPO Denial ☐ Not a Duplicate	☐ Fee Schedule Amount Incorrect ☐ PA on File ☐ Medicare EOB Attached	☐ Requested Comparable Code Attached ☐ Requested Notes or Records Attached ☐ Requested Other Coverage ☐ Other
Comments:		

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

PO Box 1630, Brookfield, WI 53008-1630 | P: 1.877.514.2442 | F: 262.754.9690
Visit our website at www.CommonGroundHealthcare.org or www.CGCares.org