



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: _____ <div style="text-align: center;">Street Number and Name</div> <div style="display: flex; justify-content: space-between;"> _____ _____ _____ </div> <div style="display: flex; justify-content: space-between;"> City State Zip Code </div>

Member Name: _____

Member ID No.: **WX**_____

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.

WAIVER OF LIABILITY STATEMENT

Medicare/HIC Number

Enrollee's Name

Provider

Dates of Service

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature

Date