Claim Reconsideration

Date: ______________________________

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

Contact Name: _____________________________________
Company: _____________________________________
Telephone: _____________________________________
Email: _____________________________________

RE: Patient Name: _____________________________________
CGHC Member ID #: _____________________________________
Date of Birth: _____________________________________
Date of Service: _____________________________________
Charged Amount: ______________________________
Claim Number (if available): ___________________________

Provider Name: _____________________________________
Provider TIN: _____________________________________

Subject: ☐ Payment
☐ Benefit
☐ Medical Necessity
Narrative:

Date of Service (mm/dd/yyyy)	CPT Code	Charged Amount	Modifiers	Expected Reimbursement
		$		

NOTE: If multiple claims, please attach spreadsheet with the columns as labeled above and include the claim number if possible for all reconsideration.