LAKELAND CARE
Together, we build better lives.

N6654 Rolling Meadows Drive
Fond du Lac, WI 54937
Phone: 920-906-5100
Toll-Free: 877-227-3335
Fax: 920-906-5158

Claim Appeal Submission Information

If you have questions regarding a partial payment or denial that cannot be resolved by the WPS/Family Care Contact Center, please contact Lakeland Care, Inc. at Claims@lakelandcareinc.com.

Your situation will be reviewed, and you will be advised of your options. If you have a dispute and it cannot be resolved with Lakeland Care staff, you will be instructed to file a formal appeal to the Lakeland Care Claims Department.

If you wish to file a formal appeal, please complete the Claim Appeal Submission form and submit along with copies of the following:

- Claim(s) in dispute
- WPS Provider Remittance Advice (PRA) or WPS denial letter
- Explanation of Medicare Benefit (EOMB) or other primary insurance PRA if applicable
- All other documentation to support or explain your appeal

The Claim Appeal Submission form along with the documentation listed above must be received at Lakeland Care, Inc. within 60 calendar days from the date on the WPS PRA or WPS denial letter indicating the denial or partial payment. The appeal can be submitted using one of the following methods:

Email: Claims@lakelandcareinc.com
Attn: Claims Appeal

Fax: (920) 906-5158
Attn: Claims Appeal

Mail: Lakeland Care, Inc.
Attn: Claims Appeal
N6654 Rolling Meadows Drive
Fond du Lac, WI 54937

You have the right to appeal to the Department of Health Services (DHS) if you do not receive a response to the appeal within 45 calendar days or if you are not satisfied with Lakeland Care's decision on the appeal. All appeals to DHS must be submitted in writing within 60 days of Lakeland Care's final decision or failure to respond. The submission must be clearly marked as an **"Appeal"** and indicate provider name, address, date of service, date of billing, date of rejection, and reason(s) for the request for reconsideration or appeal. DHS appeals can be submitted using one of the following methods:

Fax: (608) 266-5629

Mail: Provider Appeals Investigator
Division of Medicaid Services
1 West Wilson Street, Room 518
PO Box 309
Madison, WI 53701-0309

December 2020

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Claim Appeal Submission Form

Provider Information			
Billing Name		Tax ID	
Address	City	State	Zip

Contact Information for Person Submitting Form			
Name			
Phone		Email	
Address	City	State	Zip

Member Information		
Member Name	Member ID (9 Digit #)	Date of Birth (mm/dd/yyyy)

Appeal Information
Date(s) of Service
Procedure Code(s)
Appeal Amount ($)
Reason your claim(s) merit reconsideration. Please provide a detailed explanation.

Signature	Date (mm/dd/yyyy)