SisCo
Experience the Benefits

Claim Reconsideration/Appeal Form

*Please complete form in its entirety for proper appeal handling. Incomplete forms will be returned with appeal and not reviewed.
*Forms must be completed by the covered member or authorized representative.

Member Information
Member Name: _____ Member ID Number: _____

Patient Name: _____ Telephone Number: _____

Requester's Information
Requester name & title if applicable: _____

Telephone Number: _____

Mailing Address: _____

Claim Information
Date of Service(s): _____ Claim Number(s): _____

Charge Amount:_____ Supporting Documentation attached Yes ☐ No ☐

Provider Name: _____

Reason for Request
☐ 1. Claim denied "Submitted after filing deadline" (Must include address or payor ID the claim was sent to)
☐ 2. Submission of a corrected claim (Identify correction in space below)
☐ 3. Claim denied per coding review. (Documentation required)
☐ 4. Other (include explanation in appeal)

Please include a detailed explanation of your appeal and attach any and all documentation including medical records, EOBs, itemized statements, or any other critical items you feel is necessary to support the appeal. **Appeals must be filed within 180 days of the date on the original Explanation of Benefits or original letter of denial.** Please allow 60 days for review of the appeal.

Mail Appeals To:
SISCO Benefits
Attention Appeals
PO Box 389
Dubuque, IA 52004-0389
Fax #: 563-587-6718 / Email: SiscoAppeals@cb-sisco.com