

For WILMAPC Use Only

Date Received _____

Review Date _____

Provider Notice of Appeal

<u>Provider Name:</u>		<u>Provider Address:</u>	
<u>Practice Name:</u>		<u>Provider Type:</u>	<u>Provider Specialty (if applicable):</u>
<u>Provider E-mail Address :</u>		<u>Phone #:</u>	<u>Fax #:</u>
<u>Contact Name (if other than provider):</u>		<u>Phone # for Contact Person:</u>	<u>Fax # for Contact Person:</u>

I am appealing removal from the WILMAPC Provider Panel.

The basis of appeal is as follows (attach supporting documentation, if applicable):

Check here if additional information is attached.

By signing below, I affirm that the information submitted herein is true and accurate to the best of my knowledge and that I have not included any information which I am not legally permitted to share with WILMAPC. I further agree to indemnify and hold WILMAPC harmless from and against any and all losses, expenses and/or damages sustained as a result of, or arising out of, my providing legally protected information with my appeal. I also acknowledge that I have read and understood the relevant deadlines contained in the "Instructions to Providers For Filing an Appeal." **WILMAPC's decision regarding this appeal is final.**

Signature
Date