



## Provider Clinical / Claim Appeal form

<b>Please note the following to avoid delays in processing clinical / claims appeals:</b>		
Include supporting documentation • Incomplete submission will be returned for additional information • Applicable timely filing limits apply		
<b>Please indicate the following patient information:</b>		
Member Name _____	Date of Service _____	
Member ID Number _____	Code / Service not covered _____	
	Place of Service _____	
<b>Please indicate the following provider information:</b>		
Provider Name _____	CareSource Provider ID _____	
Provider NPI Number _____	Claim Number _____	
Provider Telephone Number (____) _____	Requestor Name _____	
<b>Select the most appropriate appeal type:</b>	<b>Required Documentation:</b>	
<input type="checkbox"/> <b>Claims Appeal</b> — An adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member.	<ul style="list-style-type: none"> <li><b>Appeal Form</b></li> <li><b>Supporting Documentation</b></li> <li><b>Original Remittance Advice</b></li> </ul> <p style="font-size: small;">The provider / Facility rendering services has 365 days from the date of service to file a claim appeal.</p>	
<input type="checkbox"/> <b>Clinical Appeal</b> — A request to review a determination not to certify an admission, extension or stay, or other health care service conducted by a peer review who was not involved in any previous adverse determination / non-certification decision pertaining to the same episode or care.	<ul style="list-style-type: none"> <li><b>Appeal Form</b></li> <li><b>Records supporting medical necessity</b></li> <li><b>Original Remittance Advice</b></li> </ul> <p style="font-size: small;">The provider / facility rendering services has 180 days from the date of service to file a clinical appeal.</p>	
<input type="checkbox"/> <b>Corrected Claim</b> — Any correction of the date of service, procedure / diagnosis code, incorrect unit count, location code and / or modifier to a previously processed claim. <ul style="list-style-type: none"> <li>Resubmit only the denied line(s) with updated information as a new claim. Please <b>do not</b> resubmit the entire claim (unless the entire claim was denied) as our system will auto deny the submission as a duplicate claim. If you disagree with the amount paid on a claim line, you will need to submit an appeal.</li> </ul>	<div style="display: flex; align-items: center;"> <p><b>STOP Please send Corrected Claims to:</b></p> <p>CareSource            ATTN: Claims Dept.            P.O. Box 1307            Dayton, OH 45401-1307</p> </div>	
<b>Reason for appeal request:</b>		
<b>Mail or fax all information to:</b>		
<b>Claims Appeals Department</b> P.O. Box 2008 Dayton, OH 45401-8730	<b>Clinical Appeals Department</b> P.O. Box 1947 Dayton, OH 45401-8730	<b>Fax to: Provider Claims Appeal Coordinator</b> <b>Fax Number: 937-531-2398</b>