



## Provider Claim Appeal Request Form

*Please provide the following information, if applicable:*

Provider's Name: \_\_\_\_\_

Provider's ID Number: \_\_\_\_\_

Provider's NPI Number: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Member's Name: \_\_\_\_\_

Member's ID Number: \_\_\_\_\_

Member's Date of Birth: \_\_\_\_\_

Code/Service not covered: \_\_\_\_\_

Place of Service: \_\_\_\_\_

Date(s) of Service(s): \_\_\_\_\_

Reason for appeal request: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please attach any additional information to be considered for this appeal request, such as a copy of the unpaid claim, a copy of the patient's medical record, or any other pertinent clinical information.

Mail to: CareSource, P.O. Box 2008, Dayton, OH 45401-2008

Fax to: 937-531-2398