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: ____

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Date(s) of Service(s): ____

Reason for appeal request: ____

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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

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MI-P-150