



P.O. Box 23037, Lansing, MI 48909-3037  
Phone: (800) 390-7102 \*\* Fax: (800) 480-5313

## PROVIDER CLAIM RESEARCH REQUEST

Fax to: (937) 224-3388

**Requestor Information:****Date:**

Name: ❶	Phone #:	Fax #:
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**Servicing Provider Information:**

Name: ❷	Provider ID: ❸
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**Payment Information:**

Name: ❹	Tax ID#:
Billing Address:	

**Member Information:**

Name: ❺	Member ID#:
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**Claim Information:**

CareSource Claim#: ❻	Date of Service:
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Please describe the claim issue below. Be sure to attach a copy of the claim, CareSource's EOP, other insurance carrier information, and any other information that will help us investigate your issue. Multiple claims for the same issue may be attached.

Comments ❼

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Number of Claims included in Request: ❽

For Dayton Use:

Date Completed: \_\_\_\_\_ Completed by: \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# Instructions for Project Claim Research Request Form

- ❶ Complete requestor information. Include your name, phone and fax numbers. This information is required so that CareSource may contact you about your request and that we may inform you by fax of the resolution.
- ❷ & ❸ Complete the Servicing Provider Information. This information helps us locate the claim and ensure processing was to the correct provider.
- ❹ Complete Payment information. Include the name of the entity that is to be reimbursed, the Tax ID number and the payment address.
- ❺ Complete Member Information including the Member's Medicaid ID number. If you have multiple claims for many members, please use "Please See Attached" and attach copies of each claim in your request.
- ❻ Complete Claim information by providing CareSource's Claim Number from the remit. For multiple claims, please use "Please See Attached", and attach copies of your claims and/or CareSource remits.
- ❼ Comments. Please tell why you are sending your claim issue to be researched. Provide enough information that will help us understand the issue.

Examples:

- Claim denied for Other Carrier Information. Member has no other insurance. Please see documentation attached and investigate for other insurance.
  - Removing or adding charges. Corrected claim attached.
- ❽ Please include the number of claims you are attaching to your request.
  - ❾ Please fax your request to (937) 224-3388. Your request will be researched within 30 days of receipt.

Once the research has been completed, the request form will be returned to you at the fax number you provided. We will provide information on the reprocessing of your claim(s), or an explanation as to the reason the claim(s) could not be reprocessed.

At that time if you still have questions or your claim was not resolved to your satisfaction, please contact your Provider Relations Representative at (800) 390-7102 and they will be happy to assist you.