



## Provider Clinical / Claim Appeal form

Include supporting documentation • Incomplete submission will be returned for additional information • Applicable timely filing limits apply		
<b>Member Name</b> _____  <b>Member ID Number</b> _____	<b>Date of Service</b> _____  <b>Code / Service not covered</b> _____  <b>Place of Service</b> _____	
<b>Provider Name</b> _____  <b>Provider NPI Number</b> _____  <b>Provider Telephone Number (_____)</b> _____	<b>CareSource Provider ID</b> _____  <b>Claim Number</b> _____  <b>Requestor Name</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 the entire claim with updated information as a <b>Corrected Claim</b>. 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; justify-content: center;"> <div style="background-color: black; color: white; padding: 10px; margin-right: 10px; font-weight: bold; font-size: 24px;">STOP</div> <div> <p><b>Please send Corrected Claims to:</b></p> <p>CareSource            ATTN: Claims Dept.            P.O. Box 8730            Dayton, OH 45401-8730</p> </div> </div>	
<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> Fax Number: 937-531-2398