CareSource

Return to CareSource by:
Fax: (937) 224-3388
Mail: P.O. Box 8730 Dayton, OH 45401-8730

Claims Recovery Request Form

(Please refer to the Provider Appeal Request Form to dispute payment)

REMITTANCE MUST BE ATTACHED

Provider Name:
National Provider Identifier (NPI):
Remittance Address *(as it appears on the EOP)**:***
Contact Person Name: **Phone Number:** ( )

Reason for Adjustment Request: Overpayment ____ Primary Insurance ____ Other _____

Total Number of Claims: _____

Check Enclosed: Yes ____ No ____ **If yes,** Check Number _____ Check Amount _____

Claim Type: Physician ____ Hospital ____ Home Health ____ Dental ____ Vision ____ Other _____

Member Name	Member ID	Begin Date of Service	End Date of Service	Claim Number	Reason for Adjustment

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