Note: The most current versions of the forms listed above can be found by visiting www.caresource.com, click the “Provider” tab, then “Provider Materials,” and then “Forms.”

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## Breast Pump Prescription

<table>
<thead>
<tr>
<th>Physician's Office:</th>
<th>Patient Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Duration

**Duration of Need:** ___________________________  **Start Date:** ___________________________

### Check the Product Needed and Indicate Reason for Need:

- **E0602 – Breast Pump, Manual**
  - CareSource will allow E0602 (Manual Breast Pump) for purchase if the below need is indicated:
    - Mother returning to work/school

- **E0603 – Breast Pump, Electric**
  - CareSource will allow E0603 (Electric Breast Pump) for purchase if one of the below needs are indicated:
    - Infant illness (specify)
    - Difficulty with “latch on” due to physical, emotional, or developmental problems of mother or infant (specify)
    - Mothers returning to work/school prior to six weeks postpartum with a plan for use approved by WIC

- **E0604 – Breast Pump, Hospital Grade Electric HG (Rental)**
  - CareSource will allow E0604 (Lactation Pump, Hospital Grade Electric HG-Rental) for a period not to exceed six months if one of the below needs is indicated:
    - Separation of infant from mother when infant is or remains hospitalized and mother has been discharged
    - Any maternal illness, disease or use of medication that requires the breastfeeding mother to “pump and dump” to maintain her milk supply for a limited period of time in order to resume breastfeeding when it is safe to do so

### Diagnosis Codes

- **24.1, Lactating mother**
- **Other:** _____________________________________________________________________________

By my signature below, I confirm that the patient is being treated by me. All the information contained on this form accurately reflects the patient’s needs. The patient/caregiver is able to follow instructions and is able to use the ordered product. For insurance requirements, I will maintain this signed original document in the patient’s medical record file for post-payment review/audit purposes.

**Signature:** ___________________________  **Date:** ___________________________  

Please fax the completed prescription to the CareSource participating Durable Medical Equipment Company of your choice. The pump will be delivered to the CareSource member.
Case Management Referral

CareSource's Case Management program is a fully integrated health management program that strives for member understanding of and satisfaction with their medical care. More importantly, it's designed to support the care and treatment you provide to your patient. If you know of a CareSource member that would benefit from case management, please complete and fax this form to 1-877-946-2273.

Date:

Patient name:

DOB:

Patient address:

Patient phone number (home):

Patient phone number (cell):

Patient phone number (work):

Medicaid Identification Number (MMIS#):

Referring Physician: Office Contact:

Physician Phone Number:

Primary Diagnosis:

Secondary Diagnosis:

Reason for referral to Case Management (check all that apply):

☐ Case Manager ☐ Social Worker ☐ Home Health Care ☐ Other

Comments:

If you have comments or questions, please call us at 1-800-488-0134 (TTY: 1-800-750-0750), or fax your referral to 1-877-946-2273.
# Claims Recovery Request Form

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

**Remittance MUST be Attached**

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>National Provider Identifier (NPI):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remittance Address <em>(as it appears on the EOP)</em>:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Person Name:</th>
<th>Phone Number: (     )</th>
</tr>
</thead>
</table>

**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 ______________________________________________________________________________________

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Member ID</th>
<th>Begin Date of Service</th>
<th>End Date of Service</th>
<th>Claim Number</th>
<th>Reason for Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>Member Name</td>
<td>Member ID</td>
<td>Begin Date of Service</td>
<td>End Date of Service</td>
<td>Claim Number</td>
<td>Reason for Adjustment</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------</td>
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<td>--------------------</td>
<td>--------------</td>
<td>-----------------------</td>
</tr>
</tbody>
</table>

© 2010 CareSource. All Rights Reserved. OH-P-258 / MI-P-258
SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual: ___________________________________ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the “Act”) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF PARTY SEEKING REPRESENTATION ________________________________ DATE ____________

STREET ADDRESS ____________________________________________________________ PHONE NUMBER (with Area Code) __________________________

CITY ______________________________________________________________________ STATE ______ ZIP __________

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, ________________________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party’s representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an __________________________________________________________________ (PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE OF REPRESENTATIVE ________________________________ DATE ____________

STREET ADDRESS ____________________________________________________________ PHONE NUMBER (with Area Code) __________________________

CITY ______________________________________________________________________ STATE ______ ZIP __________

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing __________________________________________ before the Secretary of the Department of Health and Human Services.

SIGNATURE ____________________________________________________________ DATE ____________

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

SIGNATURE ____________________________________________________________ DATE ____________
Confidential Fraud, Waste, and Abuse Reporting Form

Please use this form to tell us about any fraud, waste, and abuse concerns you may have. This information will be confidential. Give as much information as you can.

I am concerned that the following individual, who can be reached at the address and phone number listed below, is doing something fraudulent or abusive.

Name: ____________________________________________
Address: _________________________________________
Phone(s) __________________________________________

This person is a/an...: (please check the appropriate box)

Employee [ ] Member [ ] Provider [ ] Other* [ ]

Describe your concern? Please attach additional pages, if needed.
*Please explain the relationship between the person you are reporting and CareSource or yourself.

________________________________________________________________________
________________________________________________________________________

You may remain anonymous and not tell us your name. If you don’t want to remain anonymous, please give us the following information so that we may contact you if we need additional information.

Your Name: ____________________________________________
Your Address: _________________________________________
Your Phone No(s): ______________________________________

If you have documents that we should review, please attach them or tell us where to find them:

________________________________________________________________________

To remain anonymous, send this form (and any other documents) by mail to:
    CareSource
    Attn: Special Investigations Unit
    P. O. Box 1940
    Dayton, Ohio 45401-1940

You may also submit this form by fax or e-mail. However, sending your report this way will show the number of the fax machine or your e-mail address. If you want to be anonymous, mail the form and attachments. If you do not want to be anonymous, you may send your information using these methods:

Fax: 1-800-418-0248

E-mail: fraud@caresource.com.(copy the form information and attachments into the e-mail or attach them as documents).

If you have any questions, call us on the Fraud Hotline at 1-800-488-0134, and selecting the appropriate menu option.

OH-P-315
EXPLANATION OF PAYMENT

PAYMENT DATE: 10/20/2010
PAYEE ID: 987654321
CHECK NUMBER: NA
CLAIM COUNT: 0001
TOTAL CHARGES: $3,478.00
TOTAL PAYMENT: $180.13
PAYMENT AMOUNT: $180.13

If you have questions, please visit our Provider Portal at www.caresource.com 24 hours a day, 7 days a week.

Medicaid: CFC, ABD
Medicare: SNP
Montgomery County Care, Children’s Buy In

Claim Status

Total number of claims contained on this EOP

Claim Summary

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DATES FROM</th>
<th>TO</th>
<th>PROCEDURES (MODIFIER)</th>
<th>NO. OF UNITS</th>
<th>AMOUNT BILLED</th>
<th>ALLOWED</th>
<th>PAYMENT</th>
<th>PATIENT RESPONSIBILITY</th>
<th>OTHER INS. PAID</th>
<th>NOT COVERED</th>
<th>ADJUSTMENT REASON</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1C00C4</td>
<td>01/01/04</td>
<td>12/31/04</td>
<td>0440 <strong>SGLP</strong> 11 C0321 1 45404-189841 -C01-P00000-1</td>
<td>1</td>
<td>05.00</td>
<td>20.00</td>
<td>20.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>CR-57</td>
<td></td>
</tr>
<tr>
<td>C1C00C4</td>
<td>01/01/04</td>
<td>12/31/04</td>
<td>0440 <strong>SGLP</strong> 11 C0321 1 45404-189841 -C01-P00000-1</td>
<td>1</td>
<td>27.00</td>
<td>10.00</td>
<td>10.00</td>
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<td>0.00</td>
<td>CR-57</td>
<td></td>
</tr>
<tr>
<td>C1C00C4</td>
<td>01/01/04</td>
<td>12/31/04</td>
<td>0440 <strong>SGLP</strong> 11 C0321 1 45404-189841 -C01-P00000-1</td>
<td>1</td>
<td>27.00</td>
<td>10.00</td>
<td>10.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>CR-57</td>
<td></td>
</tr>
</tbody>
</table>

Claims adjusted on current or previous EOPs

Uns field is limited to 2 digits

Coordination of Benefits
Amount Paid by Primary

HIPAA Standard Codes — Explanation Key found at end of EOP

ADJUSTMENT REASON CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR-57</td>
<td>Payment is incurred in the allowance for another service/procedure.</td>
</tr>
<tr>
<td>CR-22</td>
<td>Payment is adjusted because the care may be covered by another payer per coordination of benefits.</td>
</tr>
<tr>
<td>CR-45</td>
<td>Change exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).</td>
</tr>
</tbody>
</table>

For more information on HIPAA compliant codes, visit http://www.wpc-edi.com/codes

120  CareSource Provider Manual  www.caresource.com
Healthchek Checklist

Date: __________  Patient Name: ________________________________

Allergies: ___________________________________________________
Medications: ________________________________________________

Medical History:  ☐ Unremarkable
Family History:  ☐ Unremarkable
Substance Use (drugs, ETOH, tobacco): ____________________________

Sexual History/Contraception: ________________________________

Pelvic Exam:  ☐ Testicular Exam: ☐ __________

Height/Weight/Percentiles: _____/_____%  _____/_____%  _____/_____%
Head Circumference/Percentile (birth-age 2): _____/_____%
Pulse: _____  Respiration:_____  BP: _______

ENT Assessment:  ☐ Normal
Gross/Fine Motor Development:  ☐ Normal
Communication Skills:  ☐ Normal
Social/Emotional Development:  ☐ Normal
Cognitive Skills:  ☐ Normal
Nutritional Assessment:  ☐ Normal
Ophthalmoscopic, Internal (birth-age 3), External (age 3-20):  ☐ Normal
Hearing Assessment, External (birth-age 3), Pure Tone (age 3-20):  ☐ Normal
Dental Assessment - Structure, Caries Inspection:  ☐ Normal
☐ Dental Appointment (age 2 and older)
☐ Immunization and Healthchek Schedule

Lead Level-Age 1: _____ mcg/Dl  Lead Level-Age 2: _____ mcg/Dl
Hemoglobin-Age 1: _____ g/Dl  Hemoglobin-One time, age 12-20: _____ g/Dl

Health Education Conducted:  ☐ Bottle caries  ☐ Healthy lifestyle
☐ Community resources  ☐ Accident/Disease prevention  ☐ Follow-up

Remarkable Findings/Other:  

OH-P-74
Interpreter Service Request Form

Request Date: ________________________________
Name of person requesting service: ________________________________
Contact phone #: ________________________________

**Member Information**

Member Name: ________________________________
DOB: ________________________________
Parent’s name if member is a minor: ________________________________
Phone #: ________________________________
CareSource ID#: ________________________________
Member’s Language/Communication mode: ________________________________

**Additional Family Members**

Member Name: ________________________________
CareSource ID# & DOB: ________________________________
Member Name: ________________________________
CareSource ID# & DOB: ________________________________

**Appointment Information**

Date of service: ________________________________
Time of appointment: ________________________________
Approximate length of appointment: ________________________________
Facility Name: ________________________________
Office/Provider Name: ________________________________
Address 1: ________________________________
Address 2 (Suite #, Building#/name, etc.): ________________________________
City, State Zip: ________________________________
Phone #: ________________________________
Any specific directions: ________________________________

Completed forms can be emailed or faxed for processing:
Email – CareSourceMemberInquiry@CareSource.com
Fax – (937) 226-6916

OH-P-333
Medical Necessity Appeal Request Form

This form is not required to submit an appeal. Please print or type all information.

Today’s Date: ____________________

Provider’s Name: ___________________________ Participating Provider?  □ Yes  □ No

If yes, please provide CareSource Provider ID Number: _________________________________

Member’s Name: _________________________________________________________________

CareSource Member ID Number: _______________________ Date of Birth: ________________

Date(s) of Service: _______________________________________________________________

Service(s) Not Covered: ___________________________________________________________

Claim Number(s): ________________________________________________________________

For DME/Orthotics, please provide code(s): _________________________________________

Reason for appeal request. Please include any relevant supporting clinical documentation:

Person Submitting Appeal: __________________________

Phone Number: (  ) ______ - ________

Mailing address to which response should be sent: ________________________________
Ohio Department of Job and Family Services  
ABORTION CERTIFICATION FORM

I certify that, on the basis of my professional judgment, this service was necessary because (check one box only)

1. The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; or

3. The pregnancy was a result of an act of rape and the patient, the patient’s legal guardian, or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction; or

4. The pregnancy was the result of an act of incest and the patient, the patient’s legal guardian, or the person who made the report certified in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or, in the case of a minor, with a county children services agency established under Chapter 5153. of the Revised Code; or

5. The pregnancy was a result of an act of rape and in my professional opinion the recipient was physically unable to comply with the reporting requirement; or

6. The pregnancy was a result of an act of incest and in my professional opinion the recipient was physically unable to comply with the reporting requirement.

PLEASE NOTE: The number indicators besides the empty boxes are for departmental use only.

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Physician’s Name (Please Type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Address</td>
<td>Physician’s Medicaid Provider Number</td>
</tr>
<tr>
<td>City, State, and Zip Code</td>
<td>Physician’s Signature</td>
</tr>
<tr>
<td>Patient’s Medicaid Billing Number</td>
<td>Date</td>
</tr>
</tbody>
</table>

OAC 5101:3-17-01 required completion of this form in order to receive Medicaid reimbursement.

JFS 03197 (Rev. 3/2005)
Guidelines for completing the
ODJFS ACKNOWLEDGEMENT OF Hysterectomy INFORMATION
JFS 03199 (Rev 4/2011)

Section I: Patient Information – always complete

1. Patient’s first and last name
2. Name of patient’s representative (if any)
3. Patient’s Medicaid number (this is the MMIS12-digit number listed on CareSource ID card)
4. Date of hysterectomy

Section II: Provision of hysterectomy information prior to hysterectomy procedure(s) – complete when Section III is NOT completed

5. Patient or representative signature acknowledging that they were informed both orally and in writing, prior to surgery
6. Date of signature
7. Name of physician representative providing procedural outcomes information (to the patient)
8. Signature of person providing information
9. Date of signature

Section III: Physician Certification of reason for not providing hysterectomy information prior to the hysterectomy procedure – complete only if the member was sterile prior to surgery or was in a life-threatening emergency situation. If Section III is completed then Section II does not need to be completed.

10. Physician indicates that the patient was already sterile before surgery
   • If this box is checked, briefly explain cause of the sterility (no attachments).
11. Physician indicates that surgery was performed under a life-threatening emergency situation
   • If this box is checked, briefly describe the nature of the emergency (no attachments).
12. Name of physician who performed the surgery (please type or print clearly)
13. Signature of physician who performed the surgery
   • This must be a signature and NOT a stamped signature.
14. Date of signature

The form must be accurately completed before CareSource can consider the claim for payment. Page _____(#) is a blank ODJFS Acknowledgement of Hysterectomy Information Form that can be reproduced and used. This form can also be accessed on our website at www.caresource.com.

April 2012
Ohio Department of Job and Family Services

ACKNOWLEDGMENT OF Hysterectomy INFORMATION

Instructions: Complete Section I and either Section II or Section III.

**Section I: Patient Information** *(REQUIRED: please type or print clearly)*

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Patient’s Representative <em>(if any)</em></td>
<td>2</td>
</tr>
<tr>
<td>Patient’s 12 Digit Medicaid Number</td>
<td>3</td>
</tr>
<tr>
<td>Date of Hysterectomy</td>
<td>4</td>
</tr>
</tbody>
</table>

**Section II: Provision of hysterectomy information prior to hysterectomy procedure(s)**

**Patient acknowledgement of receipt of hysterectomy information:**
I understand that a hysterectomy (surgical removal of the uterus), whether performed as a single procedure or together with other procedures, is medically necessary and will not be/have not been performed solely for the purpose of making me incapable of reproducing (sterile).

Prior to the hysterectomy, I have been/was informed both orally and in writing, that the hysterectomy would make me permanently incapable of reproducing (sterile).

| Patient/Representative Signature | 5 |
| Date of Signature | 6 |

**Provider acknowledgement of provision of hysterectomy information:**
Prior to the hysterectomy, I informed this patient *(and her authorized representative, if applicable)* both orally and in writing, that the hysterectomy would make her permanently incapable of reproducing (sterile).

| Name of Person Providing Information | 7 |
| Signature of Person Providing Information | 8 |
| Date of Signature | 9 |

**Section III: Physician certification of reason for not providing hysterectomy information prior to the hysterectomy procedure.**
Prior to the hysterectomy, the patient was not informed that the hysterectomy would make her permanently incapable of reproducing (sterile) because: *(check all that apply, please type or print clearly, do not provide additional attachments)*

- [ ] she was already sterile before the hysterectomy *(please briefly explain cause of the sterility)*:

- [ ] the hysterectomy was performed under a life-threatening emergency situation in which prior provision of information was not possible *(please describe the nature of the emergency)*:

| Name of the physician who performed the hysterectomy *(please type or print clearly)* | 12 |
| Signature of the physician who performed the hysterectomy | 13 |
| Date of Signature | 14 |

**FOR REIMBURSEMENT, EACH PROVIDER MUST INCLUDE A COPY OF THIS COMPLETED FORM WITH CLAIM FOR SERVICES**

Distribution: One copy to patient; one copy retained by facility; one copy retained by physician; one copy retained by anesthesiologist.

JFS 03199 (Rev. 4/2011)

126 CareSource Provider Manual  www.caresource.com
**Ohio Department of Job and Family Services**

**ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION**

Instructions: Complete Section I and either Section II or Section III.

**Section I: Patient Information** *(REQUIRED: please type or print clearly)*

<table>
<thead>
<tr>
<th>Patient's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Patient's Representative <em>(if any)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient's 12 Digit Medicaid Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Hysterectomy</th>
</tr>
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<td></td>
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</tbody>
</table>

**Section II: Provision of hysterectomy information prior to hysterectomy procedure(s)**

**Patient acknowledgement of receipt of hysterectomy information:**
I understand that a hysterectomy (surgical removal of the uterus), whether performed as a single procedure or together with other procedures, is medically necessary and will not be/has not been performed solely for the purpose of making me incapable of reproducing (sterile).

Prior to the hysterectomy, I have been/was informed, both orally and in writing, that the hysterectomy would make me permanently incapable of reproducing (sterile).

<table>
<thead>
<tr>
<th>Patient/Representative Signature</th>
<th>Date of Signature</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

**Provider acknowledgement of provision of hysterectomy information:**
Prior to the hysterectomy, I informed this patient *(and her authorized representative, if applicable)* both orally and in writing, that the hysterectomy would make her permanently incapable of reproducing (sterile).

<table>
<thead>
<tr>
<th>Name of Person Providing Information</th>
<th>Signature of Person Providing Information</th>
<th>Date of Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Section III: Physician certification of reason for not providing hysterectomy information prior to the hysterectomy procedure.**
Prior to the hysterectomy, the patient was not informed that the hysterectomy would make her permanently incapable of reproducing (sterile) because: *(check all that apply, please type or print clearly, do not provide additional attachments)*

- she was already sterile before the hysterectomy *(please briefly explain cause of the sterility)*:

- the hysterectomy was performed under a life-threatening emergency situation in which prior provision of information was not possible *(please describe the nature of the emergency)*:

<table>
<thead>
<tr>
<th>Name of the physician who performed the hysterectomy <em>(please type or print clearly)</em></th>
<th>Signature of the physician who performed the hysterectomy</th>
<th>Date of Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

FOR REIMBURSEMENT, EACH PROVIDER MUST INCLUDE A COPY OF THIS COMPLETED FORM WITH CLAIM FOR SERVICES

**Distribution:** One copy to patient; one copy retained by facility; one copy retained by physician; one copy retained by anesthesiologist.

JFS 03199 (Rev. 4/2011)
Guidelines for completing the
HHS CONSENT FOR STERILIZATION
HHS-687 (05/10)

Complete all fields unless optional is indicated.

Consent to Sterilization:
1. Name of physician or clinic providing the patient with the form
2. List the name of the surgical procedure to be performed (e.g. tubal ligation, vasectomy, etc.)
3. Patient’s date of birth
4. Patient’s first and last name
5. Name of physician who will be performing the surgical procedure
6. List the name of the surgical procedure to be performed (e.g. tubal ligation, vasectomy, etc.)
7. Patient’s signature
8. Date patient signed
   Note: The procedure cannot be performed until at least 30 days after this date and must be performed within 180 days of this date.
9. Optional: patient can check the box of their race and ethnicity

Interpreters Statement (Optional):
10. Optional: The interpreter defines the language used in the interpretation
11. Optional: The interpreter signs their name
12. Optional: The interpreter enters the date they read the statement to the patient

Statement of Person Obtaining Consent:
13. Patient’s first and last name
14. Specify type of surgical procedure performed
15. Signature of person obtaining informed consent (physician or physician representative)
16. Date consent was obtained
17. List the name of the facility (hospital, surgery center, etc.) where the procedure will be performed or the practice name of the physician performing the surgery
18. List the complete address (including city, state and zip code)

Physician’s Statement:
19. First and last name of patient to be sterilized
20. Date the surgical procedure was performed
21. List the name of the surgical procedure performed
22. This is not required unless the surgical procedure is performed less than 30 days after the patient’s signature date (in #8 above). One of the following boxes must be checked:
   - Premature delivery – indicate the expected date of delivery
   - Emergency abdominal surgery – describe circumstances
23. Signature of physician performing surgery. This must be the physician’s actual signature. Do Not Use a Signature Stamp.
24. Date the physician signs

The form must be accurately completed before CareSource can consider the claim for payment. Page _____(#) is a blank ODJFS Consent for Sterilization Form that can be reproduced and used. This form can also be accessed on our website at www.caresource.com.
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from __________________________. When I first asked __________________________ for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION I WAS BEING TOLD ABOUT IS PERMANENT AND NOT REVERSIBLE. I HAVE BEEN TOLD IF I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR BECOME A MOTHER.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as __________________________. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: __________________________. Date

I, __________________________, hereby consent of my own free will to be sterilized by __________________________, a method called __________________________. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature

__________________________ Date __________________________

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)

Ethnicity: Hispanic or Latino American Indian or Alaska Native
Not-Hispanic or Latino Asian Black or African American
Native Hawaiian or Other Pacific Islander White

INTERPRETER’S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in __________________________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Signature

__________________________ Date __________________________

HHS-687 (05/10)

STATEMENT OF PERSON OBTAINING CONSENT

Before __________________________ Name of individual signed the ____________ consent form, I explained to him/her the nature of sterilization operation ____________ , the fact that it is ____________

Specify Type of Operation

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of Person Obtaining Consent

__________________________ Date __________________________

Facility

__________________________ Address __________________________

PHYSICIAN’S STATEMENT

Shortly before I performed a sterilization operation upon __________________________ Name of Individual on __________________________ Date of Sterilization

I explained to him/her the nature of the sterilization operation ____________ , the fact that it is ____________

Specify Type of Operation

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.

(1) At least thirty days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery __________________________

Emergency abdominal surgery (describe circumstances): __________________________

Signature

__________________________ Date __________________________

Physician’s Signature
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

I have asked for and received information about sterilization from _____________________________. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____________________________.

I, _____________________________, hereby consent of my own free will to be sterilized by _____________________________.

by a method called _____________________________. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

__________________________ Date

You are requested to supply the following information, but it is not required:

(Ethnicity and Race Designation) (please check)

Ethnicity:

[] Hispanic or Latino

[] Not Hispanic or Latino

Race (mark one or more):

[] American Indian or Alaska Native

[] Asian

[] Black or African American

[] Native Hawaiian or Other Pacific Islander

[] White

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

__________________________ Date

[Interpreter's Signature]

HHS-687 (05/10)

STATEMENT OF PERSON OBTAINING CONSENT

Before _____________________________ signed the consent form, I explained to him/her the nature of sterilization operation _____________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

__________________________ Date

Name of Individual

Facility

Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____________________________ on _____________________________.

I explained to him/her the nature of sterilization operation _____________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

__________________________ Date

Signature of Person Obtaining Consent

__________________________ Date

Name of Individual

Date of Sterilization

__________________________ Date

Physician's Signature

__________________________ Date

Physician's Signature

[Physician's Signature]

[Physician's Signature]
Ohio Provider Medical Prior Authorization Request Form

☐ Routine  ☐ Urgent (72 hours)

PATIENT INFORMATION
Date of Request ___________________________ Member ID # ___________________________
Member's Last Name ________________________ First Name ____________________________
Member Address ____________________________________________________________________________
DOB ___________________________ Phone Number ___________________________

ATTACH CLINICAL NOTES WITH HISTORY AND PRIOR TREATMENT

☐ Inpatient  ☐ Outpatient
Ordering Provider Name ________________________________________________________________
Tax ID ___________________________ NPI ___________________________
Phone ___________________________ Fax ___________________________
Ordering Provider Address ________________________________________________________________
Date of Service(s) Requested ___________________________
Facility / Service Provider (First and Last Name) ____________________________________________
Provider Address ________________________________________________________________
Phone ___________________________ Fax ___________________________
Tax ID ___________________________ NPI ___________________________ DX Codes (ICD-9)
DX Description ___________________________
Additional Information ___________________________
Requested Procedures / Services / Surgery ___________________________
Procedure Codes (CPT/HCPCS) ___________________________

<table>
<thead>
<tr>
<th>Qty</th>
<th>HCPCS Code</th>
<th>Durable Medical Equipment/Orthotics/Prosthetics/Vision, Make &amp; Model, etc.</th>
<th>U&amp;C Charge</th>
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</table>

NUMBER OF VISITS
(Circle) 1 2 3 4 5 6 Other ________ visit(s); Refer back to PCP with report
☐ Update Authorization Number ____________ # of Visits ________ Requested Extension Date ____________

OTHER LIABILITY
☐ Work / Auto / Other Insurance ___________________________
This Form Completed by: ___________________________

THIS SECTION CARESOURCE USE ONLY

AUTHORIZATION INFORMATION
Authorization ☐ Approved ☐ Denied ☐ Pended ☐ Duplicate Request
Authorization Number ___________________________ # of Visits / Treatments ___________________________
Authorization To/From (Date) ___________________________
CareSource Staff Signature ___________________________ Date ___________________________

All non-par providers must have an authorization PRIOR to services rendered. Approved Prior Authorizations payment is contingent upon the eligibility of the member at the time of service, services billed must be within the provider's scope of practice as determined by the applicable fee/payment schedule and the claim timely filing limits. Authorizations are not a guarantee of payment, but are based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and/or qualifications and will be determined when the claim is received for processing.

OH-P-185c / OH-PSNP-185c
www.caresource.com

CareSource Provider Manual 131
PCP Change Request Form

Provider/Facility: _______________________________ OR Stamp: _______________________________

Tax ID#: _______________________________ Phone: _______________________________

Member Information:

Member name: (required) ______________________________________________________________

Member Phone# (required); ________________ Member ID# OR DOB (required): ______________

Other Family Members:

Member name: ___________________________ Member ID# or DOB: _______________

Member name: ___________________________ Member ID# or DOB: _______________

Member name: ___________________________ Member ID# or DOB: _______________

Reason for Change (required):

☐ No Reason - I just want different doctor on my card
☐ More convenient location/hours
☐ Referral by family/friend
☐ I am an existing patient with this doctor. I did not request this doctor when I enrolled with CareSource.
☐ Dissatisfaction - A CareSource representative will contact you upon receipt of request.
☐ I requested this PCP when I enrolled, but CareSource assigned a different doctor on my CareSource ID card.

☐ I want to be contacted by a CareSource representative to discuss the change.

The required fields must be completed for the change to be processed. Members can continue to be treated by the requested PCP until the change is complete. The member should continue to use their current ID card until the new ID card is received. All requests will be processed within 3-5 business days of receipt.

Member/Member Representative Signature _______________________________ Date: __________________

Provider (staff) Signature _______________________________ Date: __________________

Fax requests to CareSource Member Services at (937) 226-6916

OH-P-183b
Prenatal Risk Assessment Form

(Please print or type)

<table>
<thead>
<tr>
<th>Patient/Member Name:</th>
<th>Provider Name:</th>
<th>Expected Date of Delivery (EDD): (mo/day/yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Date of First Prenatal Visit:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member ID #:</th>
<th>Patient Age:</th>
<th>Provider Telephone:</th>
<th>Provider Billing Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>NPI (National Provider Identifier):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Service Referral?</th>
<th>Date:</th>
<th>Agency:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Address:</th>
<th>Provider Telephone:</th>
<th>Cell Phone:</th>
</tr>
</thead>
</table>

At Risk of Pre-term Birth

Please check all that apply. If at least one factor is checked, patient is at risk of pre-term birth – V23.8

| Obstetrical History |
|---------------------|-------------------|
| 1. Abortion, elective | 4. Eclampsia or severe pre-eclampsia |
| 2. Abortion, spontaneous | 5. Incompetent cervix |
| 3. Cone biopsy | 6. Low birth weight, less than 2500g |

| Current Pregnancy |
|-------------------|-----------------|
| 9. Abdominal surgery | 29. Malignancy or leukemia |
| 10. Age, less than 21 years | 30. Missed prenatal appointments |
| 11. Age, 35 years or older | 31. Multiple gestation |
| 12. Alcohol Abuse | 32. Oligohydramnios |
| 13. Anemia, less than 11 hgb or less than 33% hct | 33. Placenta previa |
| 14. Asthma, on medication | 34. Pneumonia |
| 15. Bleeding, if significant after 12 weeks | 35. Polyhydramnios |
| 16. Cervix dilated, more than 1.5 cm before 29 weeks | 36. Poor nutrition |
| 17. Cervix effaced, more than 50% before 29 weeks | 37. Prenatal care noncompliance, most recent pregnancy |
| 18. Chronic bronchitis | 38. Pre-term labor |
| 19. Diabetes, insulin dependent | 39. PROM, confirmed |
| 20. Diabetes, non-insulin dependent | 40. Sickle cell or other hemoglobinopathy |
| 21. Domestic Violence | 41. Smoking |
| 22. Drug Abuse | 42. Trauma |
| 23. Eclampsia or pre-eclampsia | 43. Underweight, less than 15% weight for height |
| 24. Heart disease | 44. Uterine anomaly or fibroids |
| 25. Hypertension | 45. UTI |
| 26. Irritable uterus | 46. Weight loss |
| 27. Kidney disease | 47. Other (please specify): _______________________________ |
| 28. Late initial visit, after 14 weeks of pregnancy | 48. Congenital anomaly, major |

At Risk of Poor Pregnancy Outcome

Please check all that apply. If at least one factor is checked, patient is at risk of poor pregnancy outcome – V23.9

<table>
<thead>
<tr>
<th>Obstetrical History:</th>
</tr>
</thead>
<tbody>
<tr>
<td>48. Congenital anomaly, major</td>
</tr>
</tbody>
</table>

| Current Pregnancy |
|-------------------|-----------------|
| 50. Anesthesia-related allergies | 61. HIV/ARC/AIDS |
| 51. Behavioral Health condition | 62. Illiteracy |
| 52. Deep venous thrombosis | 63. Isoimmunization associated with fetal disease |
| 53. Diabetes, gestational, diet-controlled | 64. Language barrier |
| 54. Diabetes, gestational, on medication | 65. Mental Retardation |
| 55. Epilepsy or on anticonvulsant | 66. Obesity, more than 20% weight for height |
| 56. Familial genetic disorder, confirmed | 67. Prior C-section and/or previous uterine scar |
| 57. Grand multipara, more than five of 20 weeks or more | 68. Recent delivery, less than one year |
| 58. Group B Streptococcal disease | 69. Sexually transmitted disease, any |
| 59. Height, less than five feet | 70. Thyroid disease, confirmed |
| 60. Hepatitis or chronic liver disease | 71. Other (please specify): _______________________________ |

Provider’s Signature: | Date: |
Provider Clinical / Claim Appeal form

Include supporting documentation • Incomplete submission will be returned for additional information • Applicable timely filing limits apply

<table>
<thead>
<tr>
<th>Member Name __________________________________________</th>
<th>Date of Service ______________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID Number________________________________________</td>
<td>Code / Service not covered____________________________________</td>
</tr>
<tr>
<td>Place of Service_________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

Provider Name____________________________________________  CareSource Provider ID___________________________________
Provider NPI Number  ______________________________________  Claim Number___________________________________________
Provider Telephone Number (______)__________________________  Requestor Name_________________________________________

☒ Claims Appeal — An adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member.  
  • Appeal Form  
  • Supporting Documentation  
  • Original Remittance Advice

The provider / facility rendering services has 365 days from the date of service to file a claim appeal.

☒ Clinical Appeal — 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.  
  • Appeal Form  
  • Records supporting medical necessity  
  • Original Remittance Advice

The provider / facility rendering services has 180 days from the date of service to file a clinical appeal.

☒ Corrected Claim — Any correction of the date of service, procedure / diagnosis code, incorrect unit count, location code and / or modifier to a previously processed claim.
  • Resubmit the entire claim with updated information as a Corrected Claim. If you disagree with the amount paid on a claim line, you will need to submit an appeal.

STOP Please send Corrected Claims to:
CareSource  
ATTN: Claims Dept.  
P.O. Box 8730  
Dayton, OH 45401-8730

Please send Corrected Claims to:
CareSource  
ATTN: Claims Dept.  
P.O. Box 8730  
Dayton, OH 45401-8730

©

Claims Appeals Department  
P.O. Box 2008  
Dayton, OH 45401-8730

Clinical Appeals Department  
P.O. Box 1947  
Dayton, OH 45401-8730

Fax to: Provider Claims Appeal Coordinator  
Fax Number: 937-531-2398

OH-P-182d
## Request for Reconsideration

**Instructions:** Please type or print. Leave the block empty if you cannot answer it.

*Mail to: CareSource Advantage* (HMO SNP), P.O. Box 1947, Dayton, OH 45401-1947

<table>
<thead>
<tr>
<th>1. Member Name</th>
<th>2. Identification Number</th>
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<tr>
<th>3. Representative Name (if applicable):</th>
<th>□ Relative</th>
<th>□ Attorney</th>
<th>□ Other Person</th>
<th>□ Provider Filing</th>
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<tr>
<th>4. Please attach a copy of the notice(s) you received about your claim to this form.</th>
<th>5. Social Security Number</th>
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<tbody>
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<td>_________________________</td>
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<thead>
<tr>
<th>6. This claim is for:</th>
<th>□ Hospital</th>
<th>□ Physician</th>
<th>□ Skilled Nursing Facility (SNF)</th>
<th>□ Emergency Room</th>
<th>□ Home Health Agency (HHA)</th>
<th>□ Other</th>
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<thead>
<tr>
<th>7. Name of Provider (Physician, Hospital, SNF)</th>
<th>Provider Address, City &amp; State</th>
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<tr>
<th>8. Date of Admission or Start of Services</th>
<th>9. Date(s) of the Notice(s) you received</th>
</tr>
</thead>
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</table>

10. I do not agree with the determination on my claim. Please reconsider my claim because:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

11. You must obtain any evidence you wish to submit. (Example: A letter from a doctor.)

- □ I have attached the following evidence:
- □ I will send the evidence within 10 days.
- □ I have no additional evidence or information.

12. Only one signature is needed. Signed by:

- □ Member
- □ Representative*
- □ Provider Rep

**Sign Here** — __________________

*If representative authorization needed

13. Is this request filed within 60 days of your notice?

- □ Yes
- □ No

If you checked “No”, please attach an explanation.

________________________________________________________________________

14. Street Address:

City, State Zip Code

Phone: __________________ Date: __________________

15. If this request is signed by mark (X), TWO WITNESSES who know the person requesting the reconsideration must sign in the space provided. Witnesses are ONLY required if this request has been signed by a mark (X).

<table>
<thead>
<tr>
<th>Witness #1</th>
<th>Witness #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td>City, State Zip</td>
<td>City, State Zip</td>
</tr>
</tbody>
</table>

DO NOT FILL IN BELOW THIS LINE, THANK YOU

16. Routing

17. Additional Information

18. Date Stamp

---

H6178_OHMSNP617

www.caresource.com

CMS Approved: 03/16/2012

CareSource Provider Manual 135