Appeal and Claim Dispute Form

Phone: 1-844-607-2829

CLAIM TYPE: ___ **UB-04** ___ **HCFA-1500** ___ **ADA**

PATIENT INFORMATION

DATE OF SERVICE: _____ CLAIM #: _____

NAME: _____

CARESOURCE ID NUMBER: _____ __ HIP __ HHW

PROVIDER INFORMATION

PROVIDER NPI: _____ PROVIDER TAX ID #: _____

PROVIDER NAME: _____ REQUESTOR NAME: _____

REQUESTOR EMAIL: _____ REQUESTOR PHONE: _____

REQUESTOR ADDRESS: _____

Select the most appropriate claim dispute reason:

__ Incorrect Payment
__ Authorization
__ Overpayment
__ Clinical Edit
__ Timely Filing
__ Duplicate Claim
__ Procedure Dispute
__ Eligibility
__ Consent Form
__ Coordination of Benefits
__ Recoupment
__ Provider ID Dispute
__ Appeal of Medical Necessity/Utilization Management Decision
__ Appeal of non-covered service or benefit

If this is an appeal request related to an adverse dispute decision please provide the dispute case number: _____

Description of appeal or dispute and expected outcome: _____

_____

SUBMIT APPEALS AND CLAIM DISPUTES TO:

The preferred method of submission is to submit all disputes and appeals through the CareSource provider portal.
Mail - CareSource Grievance & Appeals Department, P.O. Box 2008, Dayton, OH 45401
Fax - 937-531-2398

- *When submitting the form, include documentation which supports the appeals or claim dispute. Incomplete submissions will be returned or rejected.*
- *Providers must complete a claim dispute prior to requesting an appeal.*
- *Providers/facilities have 60 days from the Explanation of Payment (EOP) to file a claim dispute. Applicable timely filing limits will apply.*
- *If CareSource fails to decision a claim within 30 days after receipt, the 90 day submission period for the dispute begins as of the claim submission date.*

Please do NOT use this form to submit corrected claims. **Corrected claims** should be sent to:

CareSource Claims Dept., P.O. Box 3607, Dayton, OH 45401-3607.