



Provider Standard Claims Dispute Form

The preferred method of submission is through the CareSource Military & Veterans™ (CSMV) Provider Portal. However, if you are unable to do so, please complete this form and submit to the mailing address below.

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

BENEFICIARY INFORMATION

DATE OF SERVICE:	AUTHORIZATION #:
NAME:	DATE OF BIRTH:
CSMV ID #:	
CLAIM #:	

PROVIDER INFORMATION

NATIONAL PROVIDER IDENTIFIER (NPI):	
PROVIDER NAME:	PROVIDER TAX ID #:
REQUESTOR EMAIL:	REQUESTOR NAME:
PREFERRED METHOD OF COMMUNICATION: PHONE POSTAL MAIL	REQUESTOR PHONE #:
	REQUESTOR ADDRESS:

CLAIM DISPUTE REASON (SELECT THE MOST APPROPRIATE)

- | | | |
|--|--|---|
| <input type="checkbox"/> Incorrect Payment | <input type="checkbox"/> Procedure Dispute | <input type="checkbox"/> Coordination of Benefits |
| <input type="checkbox"/> Authorization | <input type="checkbox"/> Eligibility | <input type="checkbox"/> Recoupment |
| <input type="checkbox"/> Overpayment | <input type="checkbox"/> Consent Form | <input type="checkbox"/> Provider ID Dispute |
| <input type="checkbox"/> Clinical Edit | <input type="checkbox"/> Timely Filing | <input type="checkbox"/> Duplicate Claim |
| | | <input type="checkbox"/> Open Negotiation |

Description of dispute and expected outcome:

TO SUBMIT CLAIMS DISPUTES

Mail - CSMV Grievance & Appeals Department, P.O. Box 2008, Dayton, OH 45401

- When submitting the form, include documentation which supports the appeal, including but not limited to all medical records that will need to be reviewed.
- If an incomplete appeal is submitted, the provider will receive a notification indicating the request is incomplete.

For questions, please call CSMV Appeals at **1-833-230-2170**. We are available 8 a.m. to 6 p.m., Monday through Friday, Eastern Time (ET).

Please do NOT use this form to submit corrected claims. Corrected claims should be sent through Electronic Data Interchange (EDI) or mailing a red and white claim form and the primary insurance Explanation of Payment (EOP) to: **CSMV Claims Department, P.O. Box 3607, Dayton, OH 45401-3607.**

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