

Provider Disputes or Appeals

Quick Reference Guide

CareSource Military & Veterans™ providers have several opportunities to request review of claim or authorization denials.



Claim Disputes

When to Use:

When you disagree with a payment outcome or a post-service claim denial.

First formal review option – submit before a claim appeal (refer to the [Provider Manual](#) for criteria specifics and time frames).

Include All Three

- Claim identifiers
- Reason an adjustment is needed
- Supporting documentation

Important

If the submission was incorrect or requires a change, submit a corrected claim.



Claim Appeals

When to Use:

Request review of a claim denial or payment issue.

Key Points

- **Include:** claim identifiers, reason an adjustment is needed, and all supporting documentation
- If your appeal is approved, your payment will appear on the Explanation of Payment (EOP)
- Filing must be within the required time frame
- A written notice will be provided for appeal dismissals or denials

Reminder

Time frames vary by state and plan. Please reference your [Provider Manual](#).



Clinical Appeals

When to Use:

Request review of a prior authorization denial involving a clinical decision on medical necessity (refer to the [Provider Manual](#) for specific criteria and time frames).

Key Points

- Clinical denials are issued from the Utilization Management department
- May be submitted pre- or post-service
- Reviewed by clinicians not previously involved
- Will require supporting medical documentation in order to be reviewed

Note

Beneficiary written consent may be required for pre-service appeals.

How to Submit

Provider Portal (preferred) - Refer to the [Provider Manual](#) for mail and fax options.

Reminder: Time frames for disputes and appeals vary by state and plan. Refer to the [Provider Manual](#) for additional information.

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