Provider Handbook Insert

Georgia Medicaid and PeachCare for Kids® Members Enrolled in Georgia Families®

Information about requesting an appeal has changed since the 2019-2020 Provider Handbook was printed and posted on CareSource.com. The information on page 71 is outdated.

The correct information reads:

Member Appeals

A member appeal is a request for reconsideration of an adverse benefit determination. CareSource notifies members in writing when an adverse benefit determination has been made.

This can include:

• The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit

• The reduction, suspension or termination of a previously authorized service

• The denial, in whole or part, of payment for a service. Claims denied solely on the basis of not being a clean claim are not considered adverse benefit determinations.

• Failure to provide services in a timely manner

• Failure of CareSource to act within the appropriate time frame

• The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities

Members have the right to appeal an adverse benefit determination if they contact CareSource within 60 calendar days from the date on their adverse benefit determination notice. Members can contact CareSource at 1-855-202-0729 (TTY: 1-800-255-0056 or 711) to learn more about appeal procedures.

Submissions

A member, the member's authorized representative, or a provider acting on behalf of the member with the member's written consent, may file an appeal orally or in writing.

If you have questions, please call Provider Services at 1-855-202-1058 We are open Monday through Friday from 7 a.m. to 7 p.m. We are here to help.

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