Appeal and Claim Dispute Form

Phone: 1-855-202-1058

CLAIM TYPE: ___UB-04 ___HCFA-1500 ___ADA

PATIENT INFORMATION

DATE OF SERVICE:_____CLAIM #: _____

NAME: _____

CARESOURCE ID NUMBER: _____

PROVIDER INFORMATION

PROVIDER NPI: _____ PROVIDER TAX ID #: _____

PROVIDER NAME: _____ REQUESTOR NAME: _____

REQUESTOR EMAIL: _____ REQUESTOR PHONE: _____

REQUESTOR ADDRESS: _____

PREFERRED METHOD OF COMMUNICATION: _EMAIL _PHONE _POSTAL MAIL

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

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/facilities have three (3) months from the Explanation of Payment (EOP) to file a claim dispute.*
- *If an incomplete dispute is submitted, the provider will receive a letter indicating the request is complete and you will have ten (10) calendar days to resubmit.*
- *Caresource will render a Payment Dispute decision letter within fifteen (15) days of receipt.*

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

CareSource Claims Dept., P.O. Box 803, Dayton, OH 45401.

GA-P-0698a