

Appeal and Claim Dispute Form

Phone: 1-800-488-0134

CLAIM #:
_ PROVIDER TAX ID #:
_ REQUESTOR NAME:
REQUESTOR PHONE:
EMAIL PHONE POSTAL MAII
:
Appeal of Medical Necessity/Utilization n

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 ninety (90) days 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 thirty (30) 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 3607, Dayton, OH 45401-3607.