



ITEMIZED BILL COVER SHEET

Instructions for completion:

- Section 1 must be complete at the time of submission.
- The form should be typed rather than handwritten.
- Submit the cover sheet and itemized statement by secure email: ClaimsItemizedBills@CareSource.com or by sending a fax to **937-396-3173** or toll free at **844-794-1579**.
- The size of the file is limited to 12MB. Large files should be sent in multiple emails. Please fill out section 2 below accordingly. Please submit the cover sheet with each email.

Section 1 - REQUIRED

| |
|--|
| <p><u>Line of Business*:</u> _____</p> <p>*Use the following as applicable: MI Health Link</p> <p><u>Patient Name:</u></p> <p>Last: _____ First: _____</p> <p><u>HAP CareSource™ MI Health Link (Medicare-Medicaid Plan) ID:</u></p> <p># _____</p> <p><u>Dates of Service:</u></p> <p>From _____ Through _____</p> |
|--|

Section 2 – OPTIONAL (as appropriate)

| |
|--|
| <p><u>Will the itemized bill need to be split up into multiple emails due to size?</u></p> <p><input type="checkbox"/> Yes If yes, how many? _____</p> <p><input type="checkbox"/> No</p> |
|--|