Provider Standard Appeal Form

The preferred method of submission is through the CareSource Provider Portal. However, if you are unable to do so, please complete the following form and submit to the mailing address below.

PATIENT INFORMATION	
DATE OF SERVICE:	AUTHORIZATION #:
NAME:	DATE OF BIRTH:
CARESOURCE ID #:	
CLAIM #:	

PROVIDER INFORMATION	
PROVIDER NPI:	PROVIDER TAX ID #:
PROVIDER NAME:	REQUESTOR NAME:
REQUESTOR EMAIL:	REQUESTOR PHONE #:
REQUESTOR ADDRESS:	
PREFERRED METHOD OF COMMUNICATION: ___ PHONE ___ POSTAL MAIL	

SERVICE INFORMATION

What service denial is being appealed?

_____

_____

_____

Explain why this service is needed:

_____

_____

_____

TO SUBMIT APPEAL DISPUTES

Mail - CareSource Grievance & Appeals Department, P.O. Box 2008, Dayton, OH 45401

- When submitting the form, include documentation that supports the appeal. This includes, but is not limited to, all medical records that will need reviewed.
- If an incomplete appeal is submitted, the provider will receive notification indicating the request is incomplete.

For questions, please call CareSource Health Partner Appeals at **1-888-880-4889**, available 8 a.m. to 8 p.m., Monday through Friday, Eastern Time (ET).