



## **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: [claimsiteitemizedbills@caresource.com](mailto:claimsiteitemizedbills@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**

**Line of Business:** \_\_\_\_\_

**\*Use the following as applicable:** Indiana / Kentucky / Ohio / West Virginia  
Medicaid/ Marketplace / Medicare Advantage / MyCare

**Provider Contact E-mail:** \_\_\_\_\_

**Patient Name:**

Last: \_\_\_\_\_ First: \_\_\_\_\_

**CareSource ID:**

# \_\_\_\_\_

**Dates of service:**

From \_\_\_\_\_ Thru \_\_\_\_\_

### **Section 2 – OPTIONAL (as appropriate)**

**Will the itemized bill need to be split up into multiple emails due to size? :**

☐ Yes If yes, how many? : \_\_\_\_\_

☐ No