



## 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 AN APPEAL	
Mail - CareSource Grievance & Appeals Department, P.O. Box 2008, Dayton, OH 45401 <ul style="list-style-type: none"><li>• When submitting the form, include documentation that supports the appeal. This includes, but is not limited to, all medical records that will need reviewed.</li><li>• If an incomplete appeal is submitted, the provider will receive notification indicating the request is incomplete.</li></ul>	
For questions, please call Provider Services at <b>1-833-230-2101</b> , available Monday through Friday, 8 a.m. to 5 p.m. Eastern Time (ET).	