



Appeal and Claim Dispute Form

Phone: 1-855-852-5558

CLAIM TYPE: ___ UB-04 ___ HCFA-1500 ___ ADA

PATIENT INFORMATION

DATE OF SERVICE: _____ CLAIM #: _____

NAME: _____

CARESOURCE ID NUMBER: _____

PROVIDER INFORMATION

PROVIDER NPI: _____ PROVIDER TAX ID #: _____

PROVIDER NAME: _____ REQUESTOR NAME: _____

REQUESTOR EMAIL: _____ REQUESTOR PHONE: _____

REQUESTOR ADDRESS: _____

PREFERRED METHOD OF COMMUNICATION: ___ EMAIL ___ PHONE ___ POSTAL MAIL

Select the most appropriate claim dispute reason:

- | | | |
|--|---|--|
| <input type="checkbox"/> Incorrect Payment | <input type="checkbox"/> Procedure Dispute | <input type="checkbox"/> Appeal of Medical Necessity/Utilization Management Decision |
| <input type="checkbox"/> Authorization | <input type="checkbox"/> Eligibility | <input type="checkbox"/> Appeal of non-covered service or benefit |
| <input type="checkbox"/> Overpayment | <input type="checkbox"/> Consent Form | |
| <input type="checkbox"/> Clinical Edit | <input type="checkbox"/> Coordination of Benefits | |
| <input type="checkbox"/> Timely Filing | <input type="checkbox"/> Recoupment | |
| <input type="checkbox"/> Duplicate Claim | <input type="checkbox"/> Provider ID Dispute | |

Description of appeal or dispute and expected outcome: _____

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.