Provider External Review Request Form

Please complete the form below. Fields marked with an asterisk (*) are required. All required fields must be legible and complete. When submitting your request, please ensure this completed form is the first page of your submission.

The preferred methods for submitting external review requests to Humana – CareSource® are via fax or the mail:

- Provider portal: https://providerportal.caresource.com/KY/User/Login.aspx
- Fax number: 1-855-262-9793
- Mailing address: Humana – CareSource
  Attn: Appeals – External Independent Review
  P.O. Box 823
  Dayton, OH 45401-0823

***Provider name:** _____

***NPI** _____ ***Tax ID number:** _____

Claim information:

***Member name:** _____

***Member date of birth:** __/__/_____ **Humana – CareSource member ID #:** _____

***Original Claim (ICN) number:** _____

***Service from/to dates:** _____/_____

Review/Dispute type: (Please check one)

❒ **Claim denial** ❒ **Medical necessity/utilization management decision**

Request summary: _____

Contact name (please print): _____ **Title:** _____

Contact phone number: _____ **Fax number:** _____

Address for where to send notices: _____

Signature: _____ **Date:** _____

❒ **Check here if additional information is included. Please do not staple additional information to this form.**