



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 45401-1690

*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.