CareSource™

Medical Necessity Appeal Request Form

This form is not required to submit an appeal. Please print or type all information.

Today's Date: _____

Provider's Name: _____ Participating Provider? ❑ Yes ❑ No

If yes, please provide CareSource Provider ID Number: _____

Member's Name: _____

CareSource Member ID Number: _____ Date of Birth: _____

Date(s) of Service: _____

Service(s) Not Covered: _____

Claim Number(s): _____

For DME/Orthotics, please provide code(s): _____

Reason for appeal request. Please include any relevant supporting clinical documentation:

Person Submitting Appeal: _____

Phone Number: ( ) _____ - _____

Mailing address to which response should be sent: _____

_____

August 2013

OH-P-174a