Provider Standard Appeal Form

The preferred method of submission is through the HAP CareSource provider portal. However, if you are unable to do so, please complete the following form and submit it to the mailing address below.

PATIENT INFORMATION

DATE OF SERVICE:	AUTHORIZATION #:
NAME:	DATE OF BIRTH:
HAP 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 - HAP CareSource Grievance & Appeals Department, P.O. Box 2008, Dayton, OH 45401

- When submitting the form, include documentation that supports the appeal. This includes, but is not limited to, all medical records that will need reviewed.
- If an incomplete appeal is submitted, the provider will receive notification indicating the request is incomplete.

For questions, please call Provider Services at **1-833-230-2102**. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET).