Standard Appeal Form

The preferred method of submission is to submit all appeals through the HAP CareSource Provider Portal, however, if you are unable to do so, please complete the following form and submit to the mailing address below.

PATIENT INFORMATION

DATE OF SERVICE: _____AUTHORIZATION NUMBER: _____

NAME: _____

HAP CARESOURCE ID NUMBER: _____DATE OF BIRTH: _____

CLAIM NUMBER: _____

PROVIDER INFORMATION

PROVIDER NPI: _____ PROVIDER TAX ID NUMBER: _____

PROVIDER NAME: _____ REQUESTOR NAME: _____

REQUESTOR EMAIL: _____REQUESTOR PHONE: _____

REQUESTOR ADDRESS: _____

PREFERRED METHOD OF COMMUNICATION: __EMAIL __PHONE __POSTAL MAIL

SERVICE INFORMATION

What service denial is being appealed:_____

_____

Explain why this service is needed:_____

_____

_____

For any questions, please call 1-833-230-2102 from Monday to Friday from 7 a.m. to 8 p.m. Eastern Time (ET).

Mail – HAP CareSource Grievance & Appeals Department, P.O. Box 1025, Dayton, OH 45401

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