CLAIM DISPUTE 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.

CLAIM TYPE: ___ **UB-04** ___ **HCFA-1500** ___ **ADA**

PATIENT INFORMATION

DATE OF SERVICE: ______________________ CLAIM NUMBER: ___________________

NAME: ____

HAP CARESOURCE ID NUMBER: ____________ DATE OF BIRTH: ___________________

PROVIDER INFORMATION

PROVIDER NPI: __________________________ PROVIDER TAX ID #: ________________

PROVIDER NAME: ________________________ REQUESTOR NAME: _________________

REQUESTOR EMAIL: ______________________ REQUESTOR PHONE: ______________

REQUESTOR ADDRESS: ____

Select the most appropriate claim dispute reason:

__ Incorrect Payment	___Procedure Dispute	___Coordination of Benefits
__ Authorization	___Eligibility	___Recoupment
__ Overpayment	___Consent Form	___Provider ID Dispute
__ Clinical Edit	__ Timely Filing	__ Duplicate Claim

Description of appeal or dispute and expected outcome: _____________________________________

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For any questions, please call 1-833-230-2102.

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.*

Please do NOT use this form to submit corrected claims. **Corrected claims** should be sent through EDI or mailing a red and white claim form and the primary insurance Explanation of Payment (EOP) to:

HAP CareSource Claims Dept., P.O. Box 3607, Dayton, OH 45401-3607.

MI-MED-P-2194751