

Provider Disputes or Appeals

Quick Reference Guide



HAP CareSource™ and HAP CareSource™ MI Coordinated Health (HMO D-SNP) providers have several opportunities to request review of claim or authorization denials.

 Claim Disputes	 Claim Appeals	 Clinical Appeals
When to Use: When you disagree with a payment outcome or a post-service claim denial. First formal review option – submit before a claim appeal (refer to the Provider Manual for criteria specifics and time frames). Include all three • Claim identifiers • Reason an adjustment is needed • Supporting documentation Important If the submission was incorrect or requires a change, submit a corrected claim.	When to Use: Request review of a claim denial or payment issue. Key Points • Include: claim identifiers, reason an adjustment is needed, and all supporting documentation • If your appeal is approved, your payment will appear on the Explanation of Payment (EOP) • Filing must be within the required time frame • A written notice will be provided for appeal dismissals or denials Reminder Time frames vary by state and plan. Please reference your Provider Manual.	When to Use: Request review of a prior authorization denial involving a clinical decision on medical necessity (refer to the Provider Manual for specific criteria and time frames). Key Points • Clinical denials are issued from the Utilization Management department • May be submitted pre- or post-service • Reviewed by clinicians not previously involved • Will require supporting medical documentation in order to be reviewed Note Member written consent may be required for pre-service appeals.

HOW TO SUBMIT

Provider Portal (preferred) - Refer to the [Provider Manual](#) for mail and fax options.

Reminder: Time frames for disputes and appeals vary by state and plan. Refer to the [Provider Manual](#) for additional information.