Provider Standard Claims Dispute Form

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

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

PATIENT INFORMATION

DATE OF SERVICE:	AUTHORIZATION #:
NAME:	DATE OF BIRTH:
CARESOURCE ID #:	
CLAIM #:	

PROVIDER INFORMATION

NATIONAL PROVIDER IDENTIFIER (NPI):	
PROVIDER NAME:	PROVIDER TAX ID #:
REQUESTOR EMAIL:	REQUESTOR NAME:
PREFERRED METHOD OF COMMUNICATION: ☐ PHONE ☐ POSTAL MAIL	REQUESTOR PHONE #:
	REQUESTOR ADDRESS:

CLAIM DISPUTE REASON (SELECT THE MOST APPROPRIATE)

☐ Incorrect Payment
☐ Authorization
☐ Overpayment
☐ Clinical Edit
☐ Procedure Dispute
☐ Eligibility
☐ Consent Form
☐ Timely Filing
☐ Coordination of Benefits
☐ Recoupment
☐ Provider ID Dispute
☐ Duplicate Claim
☐ Open Negotiation

Description of dispute and expected outcome:

_____

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TO SUBMIT CLAIMS DISPUTES

Mail - CareSource Grievance & Appeals Department, P.O. Box 2008, Dayton, OH 45401

- When submitting the form, include documentation that supports the appeal, including but not limited to 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 Electronic Data Interchange (EDI) or mailing a red and white claim form and the primary insurance Explanation of Payment (EOP) to: **CareSource Claims Department, P.O. Box 3607, Dayton, OH 45401-3607**.