



# Standard Appeal Form

*The preferred method of submission is to submit all appeals through the 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: \_\_\_\_\_

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 1-833-230-2112. We are open Monday to Friday from 8 a.m. to 6 p.m., Pacific Time (PT).**

**Mail –CareSource, Attention: Nevada Medicaid Provider, P.O. Box 2008, 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.*