Provider Disputes or Appeals

Quick Reference Guide

CareSource providers have several opportunities to request review of claim or authorization denials.

Claim Disputes

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.

Claim Appeals

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.

Clinical Appeals

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.
Marketplace only: clinical appeals should include supporting documentation.

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.