Expedited Appeal Form

Is the appeal for a service that the patient has not yet received? _____ Yes _____ No

If "Yes", continue with this form. If "No", then use the standard appeal process.

The preferred method of submission for appeal requests is through the CareSource Provider Portal. 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 # _____

NAME _____ CARESOURCE ID NUMBER _____

DATE OF BIRTH_____ CLAIM NUMBER_____

PROVIDER INFORMATION

PROVIDER NPI _____ PROVIDER TAX ID # _____

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 and why the standard appeal process will harm the patient:

_____

_____

_____

I certify in making the request on the member's behalf or supporting the member's request, that the standard resolution time frame could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function.

Provider's Signature: _____ Date _____/_____/_____

Printed Name: _____

For any questions, please call 1-800-488-0134
CareSource Grievance & Appeals Department, P.O. Box 2008, Dayton, OH 45401

- *When submitting the form, include documentation which supports the appeal, including but not limited to 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 from Grievance and Appeals Operations.*