Provider Appeal Form

An appeal is a request for CareSource to reconsider a claim denial or a medical necessity decision. Use this form to submit an appeal.

DO NOT use this form to dispute the amount you recieved for a claim payment or to resubmit a corrected claim. Contact your Provider Representative for a claim payment dispute and resubmit a corrected claim using the claim submission process.

Fields with an asterisk (*) are required. All required fields must be completed and legible or your appeal will not be reviewed. When you submit your appeal, please be sure this form is the first page of your submission. Include all applicable supporting documentation. Timely filing limits apply.

The preferred method for submitting provider appeals to CareSource is online using the Provider Portal: https://providerportal.caresource.com/

*** Provider Name:** ____

*** NPI Number:** ____________________ *** Tax ID Number:** ____________________

Claim Information: (Check one)

❒ **Single Claim** ❒ **Multiple Claims w/ substantially similar issues (complete page 2)**

*** Member Name:** ____

*** Member Date of Birth:** __/__/______ *** CareSource Member ID #:** ____________________

*** Original Claim (ICN) Number (If multiple claims, complete page 2):** ____________________

*** Service From/To Dates:** ______________ /______________

Appeal Type: (Check one)

❒ **Appeal of Claim Denial**

❒ **Appeal of Medical Necessity**
Please be aware that written member consent is required if you are filing a pre-service appeal on behalf of a member.

Appeal Description/Reason:____

____

Contact Name (Please Print): ____________________ **Title:** ____________________

Contact Phone Number: ____________________ **Fax Number:** ____________________

Address for Appeal Decision Notices: ____

Signature: ______________________________ **Date:** ____________________

❒ **Check here if additional information is included. Please do not staple additional information to this form.**

Return this form to: **CareSource**
Attn: Provider Appeals
P.O. Box 2008
Dayton, OH 45401-2008
Fax: 937-531-2398

Use this page only for multiple "like" claims (appeals for the same reason). Fields with an asterisk (*) are required.

2. Claim Information:

*** Member Name: ____**

*** Member Date of Birth: __/__/______ * CareSource Member ID #: ________________________**

*** Original Claim (ICN) Number: ____________________________**

*** Service From/To Dates: _______________ /______________**

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3. Claim Information:

*** Member Name: ____**

*** Member Date of Birth: __/__/______ * CareSource Member ID #: ________________________**

*** Original Claim (ICN) Number: ____________________________**

*** Service From/To Dates: _______________ /_______________**

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4. Claim Information:

*** Member Name: ____**

*** Member Date of Birth: __/__/______ * CareSource Member ID #: ________________________**

*** Original Claim (ICN) Number: ____________________________**

*** Service From/To Dates: _______________ /______________**

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5. Claim Information:

*** Member Name: ____**

*** Member Date of Birth: __/__/______ * CareSource Member ID #: ________________________**

***Original Claim (ICN) Number: ____________________________**

*** Service From/To Dates: _______________ /_______________**

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6. Claim Information:

*** Member Name: ____**

*** Member Date of Birth: __/__/______ * CareSource Member ID #: ________________________**

*** Original Claim (ICN) Number: ____________________________**

*** Service From/To Dates: _______________ /_______________**