



# Appeal and Claim Dispute Form

Phone: 1-844-607-2829

CLAIM TYPE:    \_\_\_ UB-04                    \_\_\_ HCFA-1500                    \_\_\_ ADA

## PATIENT INFORMATION

DATE OF SERVICE: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

NAME: \_\_\_\_\_

CARESOURCE ID NUMBER: \_\_\_\_\_    \_\_\_ HIP    \_\_\_ HHW

## PROVIDER INFORMATION

PROVIDER NPI: \_\_\_\_\_ PROVIDER TAX ID #: \_\_\_\_\_

PROVIDER NAME: \_\_\_\_\_ REQUESTOR NAME: \_\_\_\_\_

REQUESTOR EMAIL: \_\_\_\_\_ REQUESTOR PHONE: \_\_\_\_\_

REQUESTOR ADDRESS: \_\_\_\_\_

Select the most appropriate claim dispute reason:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Incorrect Payment | <input type="checkbox"/> Procedure Dispute        | <input type="checkbox"/> Appeal of Medical     |
| <input type="checkbox"/> Authorization     | <input type="checkbox"/> Eligibility              | Necessity/Utilization                          |
| <input type="checkbox"/> Overpayment       | <input type="checkbox"/> Consent Form             | Management Decision                            |
| <input type="checkbox"/> Clinical Edit     | <input type="checkbox"/> Coordination of Benefits | <input type="checkbox"/> Appeal of non-covered |
| <input type="checkbox"/> Timely Filing     | <input type="checkbox"/> Recoupment               | service or benefit                             |
| <input type="checkbox"/> Duplicate Claim   | <input type="checkbox"/> Provider ID Dispute      |  |

If this is an appeal request related to an adverse dispute decision please provide the dispute case number: \_\_\_\_\_

Description of appeal or dispute and expected outcome: \_\_\_\_\_

## SUBMIT APPEALS AND CLAIM DISPUTES TO:

**The preferred method of submission is to submit all disputes and appeals through the CareSource provider portal.**

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

**Fax - 937-531-2398**

- *When submitting the form, include documentation which supports the appeals or claim dispute. Incomplete submissions will be returned or rejected.*
- *Providers must complete a claim dispute prior to requesting an appeal.*
- *Providers/facilities have 60 days from the Explanation of Payment (EOP) to file a claim dispute. Applicable timely filing limits will apply.*
- *If CareSource fails to decision a claim within 30 days after receipt, the 90 day submission period for the dispute begins as of the claim submission date.*

Please do NOT use this form to submit corrected claims. **Corrected claims** should be sent to:

**CareSource Claims Dept., P.O. Box 3607, Dayton, OH 45401-3607.**