IN Medicaid Provider

Claims Dispute Form

Phone: 1-1-844-607-2831

CLAIM TYPE: ___ **UB-04** ___ **HCFA-1500** ___ **ADA**

PATIENT INFORMATION

DATE OF SERVICE:_____ CLAIM #: _____

NAME:_____

CARESOURCE ID 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

Select the most appropriate claim dispute reason:

__ Incorrect Payment
__ Authorization
__ Overpayment
__ Clinical Edit
__ Timely Filing
__ Duplicate Claim
__ Procedure Dispute
__ Additional explanation of dispute: _____

_____

__ Procedure Dispute
__ Eligibility
__ Consent Form
__ Coordination of Benefits
__ Recoupment
__ Provider ID Dispute

SUBMIT CLAIMS TO:

CareSource Claims Dispute Department, 135 N. Pennsylvania St, Ste. 1300, Indianapolis IN 46204

- *When submitting the form, include documentation which supports the 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 per 405 IAC 1-1.6-1.*

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.