CareSource

Provider Clinical/Claim Appeal Form

Please note the following to avoid delays in processing clinical/claim appeals:

Include supporting documentation • Incomplete submission will be returned for additional information • Applicable timely filing limits apply

Please indicate the following patient information:

Member Name _____

Member ID Number _____

Date of Service _____

Code/Service Not Covered _____

Place of Service _____

Please indicate the following provider information:

Provider Name _____

Provider NPI Number _____

Provider Telephone Number (____)_____

CareSource Provider ID _____

Claim Number _____

Requestor Name _____

Select the most appropriate appeal type:	**Include required documentation:**
❒ **Claim Appeal** — An adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member.	• **Appeal form** • **Supporting documentation** • **Original remittance advice** The provider/facility rendering services has 365 days from the date of service to file a claim appeal.
❒ **Clinical Appeal** — A request to review a determination not to certify an admission, extension or stay, or other health care service conducted by a peer review who was not involved in any previous adverse determination /non-certification decision pertaining to the same episode or care.	• **Appeal form** • **Records supporting medical necessity** • **Original remittance advice** The provider/facility rendering service has 180 days from the date of service to file a clinical appeal.
❒ **Corrected Claim** — Any correction of the date of service, procedure/diagnosis code, incorrect unit count, location code and/or modifier to a previously processed claim**.** Resubmit the entire claim with updated information as a **Corrected Claim**. If you disagree with the amount paid on a claim line, you will need to submit an appeal.	**Please send Corrected Claims to:**  CareSource ATTN: Claims Dept. P.O. Box 3607 Dayton, OH 45401-3607

Reason for appeal request:

Mail or fax all information to:

Claim Appeals Department P.O. Box 2008 Dayton, OH 45401-2008	Clinical Appeals Department P.O. Box 1947 Dayton, OH 45401-1947	Provider Claim Appeals Coordinator Fax Number: 937-531-2398