



HAP CareSource™

ITEMIZED BILL COVER SHEET

Instructions for completion:

- Section 1 must be completed at the time of submission.
- The form should be typed rather than handwritten.
- Submit the cover sheet and itemized statement by:
 - **Secure email:** Claimsitemizedbills@CareSource.com
 - **Fax:** 937-396-3173
 - **Toll-free Phone:** 1-844-794-1579.
- The size of the file is limited to 12MB. Large files should be sent in multiple emails. Please fill out Section 2 below accordingly. Please submit the coversheet with each email.

Section 1 - REQUIRED

Line of Business*: _____

*Use the following as applicable: **Michigan Marketplace**

Patient Name:

Last: _____ First: _____

HAP CareSource ID:

Dates of service:

From _____ Thru _____

Section 2 – OPTIONAL (as appropriate)

Will the itemized bill need to be split up into multiple emails due to size?

Yes If yes, how many? _____

No