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 Marsha Bedman

Member ID Number 108109479OO

Date of Service 6-10-2020

Code/Service Not Covered Lab

Place of Service Harrison County Hospital

Please indicate the following provider information:

Provider Name Harrison County Hospital

Provider NPI Number 1851378137

Provider Telephone Number (812) 738-4251

CareSource Provider ID

Claim Number 2018104Y6EOO

Requestor Name Heather M

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. Please Reprocess Claim under Harrison County Hospital 351180407-010	• **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.	STOP **Please send Corrected Claims to:** CareSource ATTN: Claims Dept. P.O. Box 3607 Dayton, OH 45401-3607

Reason for appeal request:

Claim denid in error, processed under wrong payer entity use: 351180407010 Harrison County Hospital

Mail or fax all information to:

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

HARRISON COUNTY HOSPITAL
1141 HOSPITAL DRIVE NW
CORYDON IN 471122164
8127388755 8127387833

3a PAT. CNTL # 15000570587
b. MED. REC. # 34911
4 TYPE OF BILL 0141
5 FED. TAX NO. 0000 351180407
6 STATEMENT COVERS PERIOD FROM 061020 THROUGH 061020

8 PATIENT NAME: REDMON MARSHA
9 PATIENT ADDRESS: 773 N RADIATOR RD, ENGLISH, IN 471186936

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
09011964	F			3	2		01

31 OCCURRENCE CODE	DATE
11	061020

38:
REDMON MARSHA
773 N RADIATOR RD

ENGLISH IN 47118-6936

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0301	RIA NONANTIBODY	83519	061020	1	13800	
0001	*PAGE* 1 *OF* 1	*CREATION DATE*	072420	TOTALS	13800	000

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
CARESOURCE MARKETPLACE	999990000	Y	Y			1851378137

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
REDMON MARSHA	18	10810947900		
	00			
	00			

63 TREATMENT AUTHORIZATION CODES / 64 DOCUMENT CONTROL NUMBER / 65 EMPLOYER NAME

66 DX: E1165
0

69 ADMIT DX / 70 PATIENT REASON DX: E1165

76 ATTENDING NPI 1114476314
LAST MCCARTY FIRST ERIC

77 OPERATING NPI
78 OTHER NPI
79 OTHER NPI

80 REMARKS:
CARESOURCE MARKETPLACE
PO BOX 3607
DAYTON OH 45401-3607

81CC a: B3282NC0060X