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 Macsha Bedmon

Member ID Number 108109479 00

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 1851378139

Provider Telephone Number (812) 738-4251

CareSource Provider ID

Claim Number 2D181D4Y16E0D

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.

Please send Corrected Claims to:

STOP

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: 351180407-010 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