# OHIO MEDICAID DISPUTE FORM

**Phone: 1-800-488-0134**

***The preferred method of submission of disputes is through the CareSource PROVIDER PORTAL at https://providerportal.CareSource.com/OH. However, if you are unable to do so, please complete the following form and submit to the mailing address below.***

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

## PATIENT INFORMATION

DATE OF SERVICE:_____CLAIM #: _____

NAME: _____

CARESOURCE ID #: _____DATE OF BIRTH:_____

## 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
__ Overpayment
__ Clinical Edit
__ Authorization

___Procedure Dispute
___Eligibility
___Consent Form
__ Timely Filing
Authorization #_____

___Coordination of Benefits
___Recoupment
___Provider ID Dispute
__ Duplicate Claim

Description of dispute and expected outcome: _____

_____

**For any questions, please call 1-800-488-0134.**

**Mail - CareSource Grievance & Appeals Department, P.O. Box 2008, Dayton, OH 45401**

- *When submitting the form, include documentation which supports the dispute, including but not limited to all medical records that will need to be reviewed.*
- *If an incomplete dispute is submitted, the provider will receive a notification indicating the request is incomplete.*

Please do NOT use this form to submit corrected claims. **Corrected claims** should be sent through electronic data interchange (EDI) or mailing a red and white claim form and the primary insurance EOP to:

**CareSource Claims Dept., P.O. Box 3607, Dayton, OH 45401-3607.**