Standard Appeal Form - Provider

The preferred method of submission is through the TrueCare Provider Portal at https://providerportal.caresource.com/MS/User/Login.aspx. However, if you are unable to do so, please complete the following form and submit to the mailing address below.

PATIENT INFORMATION	
DATE OF SERVICE:	AUTHORIZATION NUMBER:
NAME:	DATE OF BIRTH:
TRUECARE ID NUMBER:	
CLAIM NUMBER:	
PROVIDER INFORMATION	
PROVIDER NPI:	PROVIDER TAX ID NUMBER:
PROVIDER NAME:	REQUESTOR NAME:
REQUESTOR EMAIL:	REQUESTOR PHONE NUMBER:
REQUESTOR ADDRESS:	
PREFERRED METHOD OF COMMUNICATION: ___PHONE ___POSTAL MAIL	
SERVICE INFORMATION	
What service denial is being appealed? _____ _____ _____ Explain why this service is needed: _____ _____ _____	

TO SUBMIT APPEAL

Mail –

TrueCare
Attn: Grievance & Appeals Department
P.O. Box 2008
Dayton, OH 45401

When submitting the form, include documentation which supports the appeal, including but not limited to all medical records that will need to be reviewed.

If an incomplete appeal is submitted, the provider will receive a notification indicating the request is incomplete.

For questions, please call Provider Services at **1-833-230-2174**.

MS-MED-P-3505850