PRIOR AUTHORIZATION 101: UNDERSTANDING THE ESSENTIALS

2025 Indiana Health Coverage Programs (IHCP) Works Annual Seminar

AGENDA

What is a Prior Authorization?

What Services Require Authorization?

How to Submit a Prior Authorization

Provider Portal

Mail or Fax

Timeframes and Updates

Special Services

Dental

Behavior Health

Retro-Authorization

Appeal Process

How to Contact CareSource

WHAT IS A PRIOR AUTHORIZATION?

PRIOR AUTHORIZATION

Prior authorization is a review process used by health insurance companies to determine if a specific medical service, medication, or procedure is eligible for coverage under a patient's plan.

- CareSource evaluates prior authorization requests based on medical necessity, medical appropriateness, and benefit limits.
- Emergency care does not need prior authorization.
- If the provider is not part of the CareSource network, a prior authorization must be obtained before any services are rendered, not just for those codes listed.

Reminder:

An authorization or notification is not a guarantee of payment, but is based on medical necessity, appropriate coding, eligibility, and benefits.

PROVIDER MAINTENANCE

Ensure your claims and prior authorization requests process without delay.

Review and update your information on file with CareSource. Incorrect information may result in prior authorization and claim rejections or denials.

Submit any changes for your practice using the Provider Maintenance Form on the Provider Portal.

Changes made to your provider profile must match the information CareSource receives from the state's provider enrollment file.

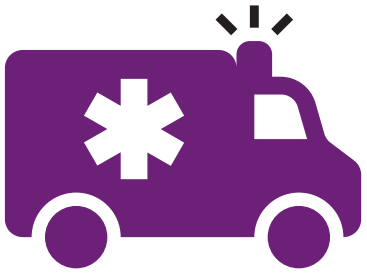
VERIFY MEMBER ELIGIBILITY AND BENEFITS

Providers are responsible for verifying member eligibility and benefits before providing services.

PROVIDER PORTAL	PROVIDER SERVICE
You can easily verify member eligibility by accessing the Provider Portal or through an eligible Electronic Data Interchange (EDI) clearinghouse.	1-844-607-2831 8 am – 8 pm EST Follow appropriate menu prompts for eligibility.

WHAT SERVICES REQUIRE AUTHORIZATION?

NON-PARTICIPATING PROVIDERS



Prior authorization must be obtained before sending patients to **non–participating providers**, with the exceptions **Emergency** Services.

Prior authorization is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a non-participating provider.

INPATIENT SERVICES

All **non-participating providers** and all requests for **inpatient services** require prior authorization.

To request prior authorization as a non–participating provider or to request authorization for any inpatient admission, call **1-844-607-2831** and follow the appropriate menu prompts. During regular business hours, your call will be answered by our Utilization Management department.

Outpatient emergency services do not require prior authorization

Note: Non-participating providers must be IHCP enrolled to receive reimbursement and claims must be submitted within 180 calendar days from date of service or discharge.

MOM AND BABY AUTHORIZATION PROCESS

CareSource does not require newborn notification.

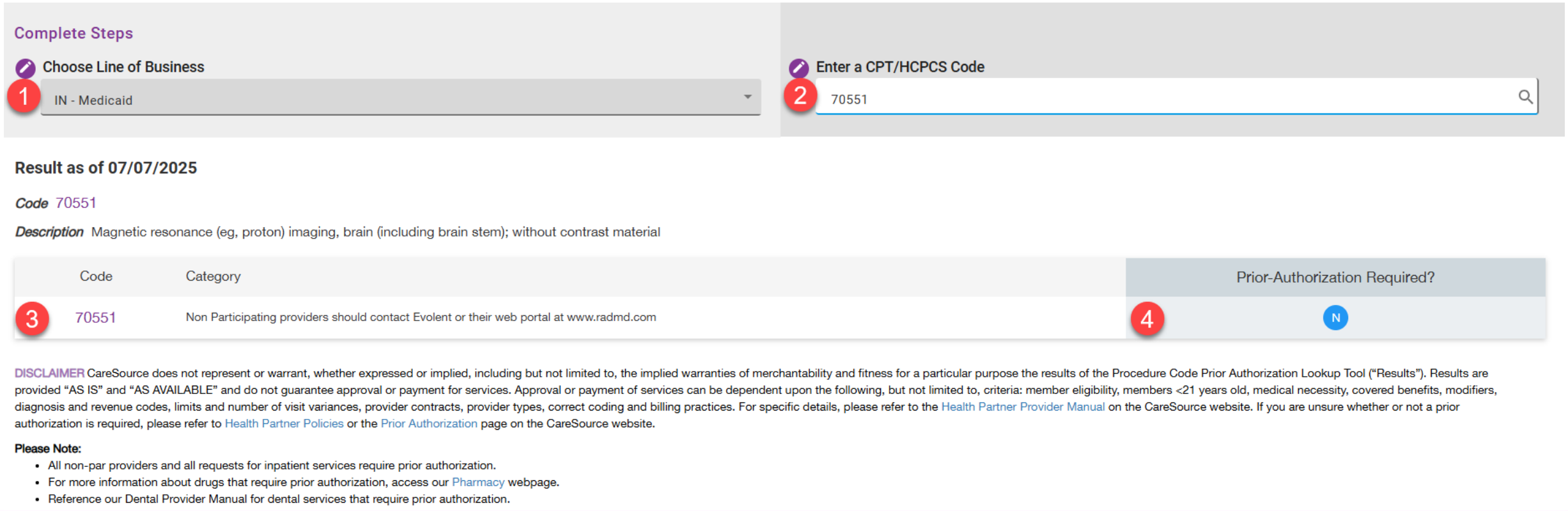
Deliveries only require authorization if:

- Inpatient stay exceeds **3 days** for vaginal delivery.
- Inpatient stay exceeds **5 days** for C-Section.
- Newborn remains inpatient after mother is discharged.
- Level of care changes for mother or newborn.

PROCEDURE CODE LOOKUP TOOL

Refer to the Procedure Code Lookup Tool to check whether a service requires prior authorization.

Prior authorization requirements may differ between Healthy Indiana Plan and Hoosier Healthwise.



HOW TO SUBMIT A PRIOR AUTHORIZATION

PRIOR AUTHORIZATION ELECTRONIC SUBMISSION MANDATE

Pursuant to Senate Enrolled Act (SEA) 480 (2025) Section 19, **effective October 1, 2025**, Indiana Medicaid Health Partners are required to submit Prior Authorizations through a secure electronic submission method or an application programming interface. There are two methods to comply with this mandate for CareSource providers:

Provider Portal (Preferred)	You can receive immediate approval and review the status of an authorization. For assistance with submitting your prior authorization or questions regarding submissions via the portal, email CiteAutoAssistance@caresource.com, and a representative will be in contact. This email is only for assistance and questions regarding prior authorizations within the Provider Portal.
FAX	Medical: 1-844-432-8924 Behavioral Health:1-937-487-1664

Faxed requests should be submitted using the Medical Prior Authorization Request Form.

EXCEPTION SUBMISSION METHODS

Health Partners unable to submit Prior Authorizations via the CareSource Provider Portal or e-fax must meet the following exception requirements:

- Financial hardship
- Lacking sufficient internet access
- Limited number of individuals covered as patients or customers to warrant compliance

Once it has been determined that a provider meets the exception requirements, these are the exception submission methods:

PHONE	1-844-607-2831 **Monday – Friday 8 am – 8 pm Eastern Time** **Confidential voicemail available 24/7**
MAIL	CareSource P.O. Box 1307 Dayton, OH 45401-1307

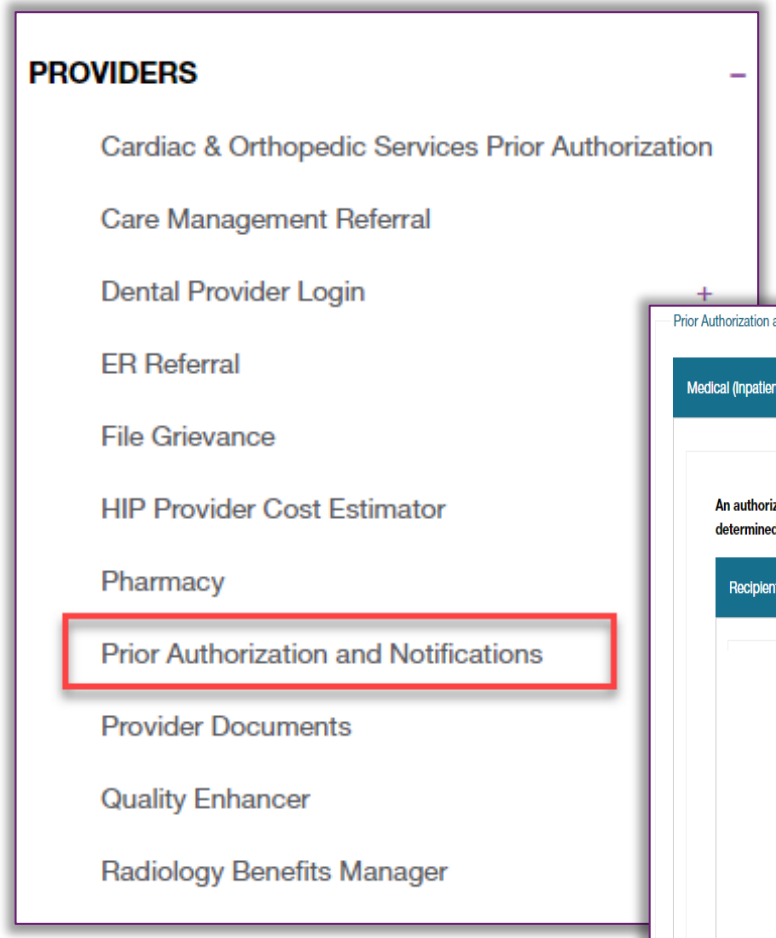
Mailed requests should be submitted using the Medical Prior Authorization Request Form.

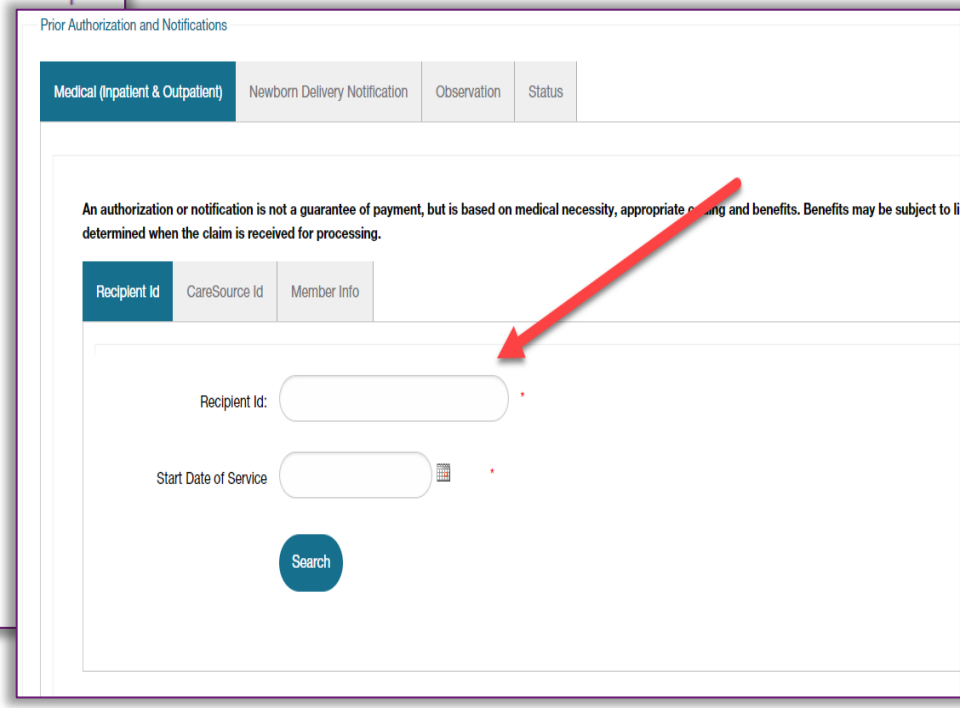
PROVIDER PORTAL

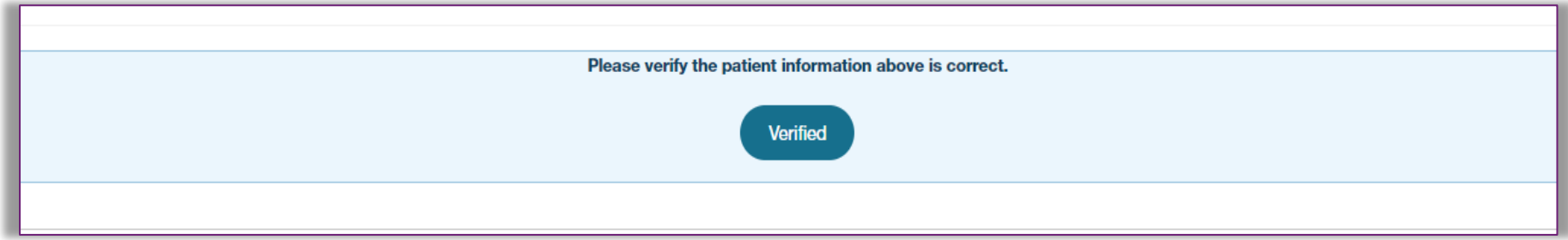
PRIOR AUTHORIZATION SUBMISSION

Access to the prior authorization form can be found by clicking **Providers** > **Prior Authorization and Notifications** from the left navigation menu.

Begin an authorization by searching for the CareSource member by Recipient ID, CareSource ID, or Member Information and the start date of service. Once the member is located, click **Verified**.



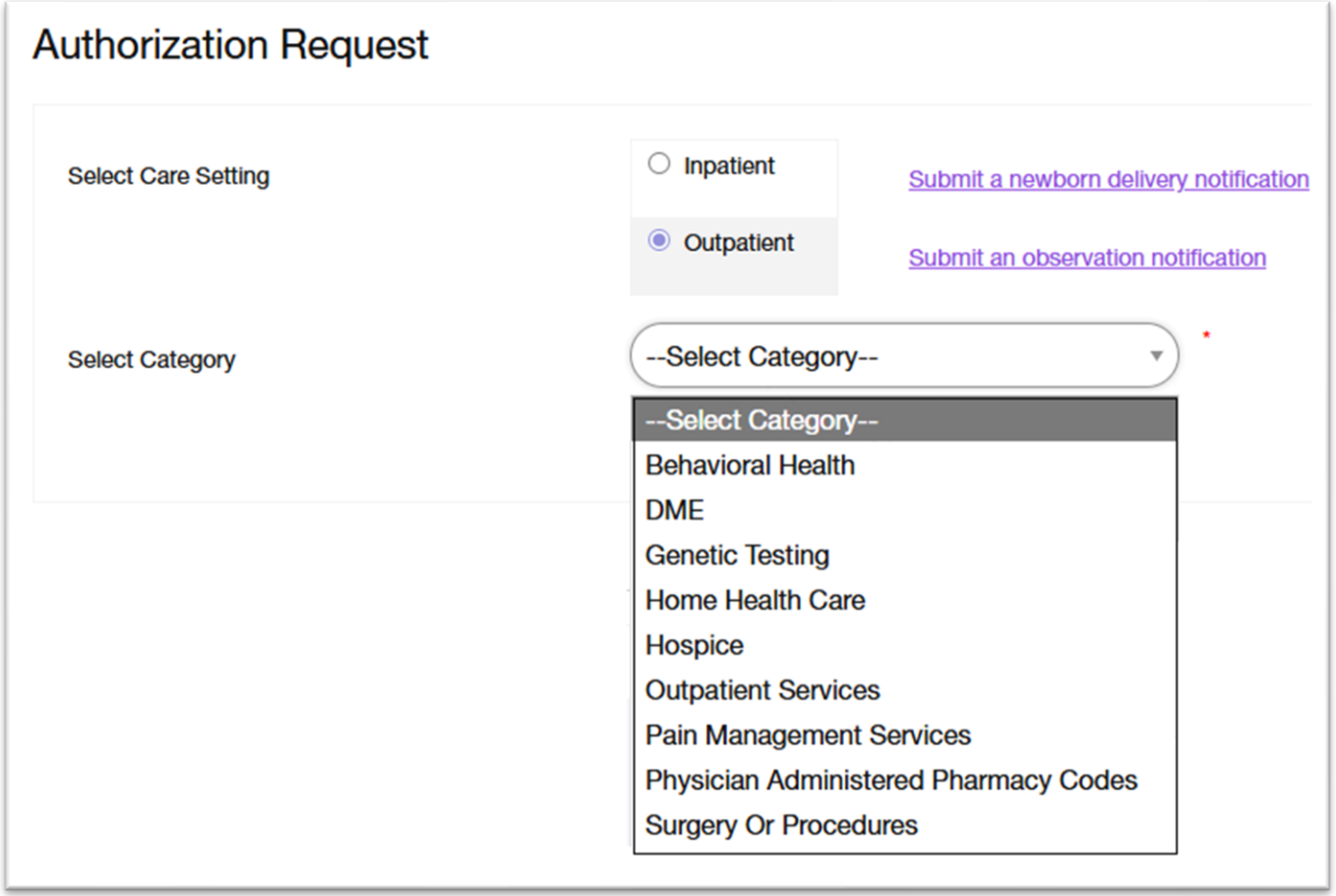




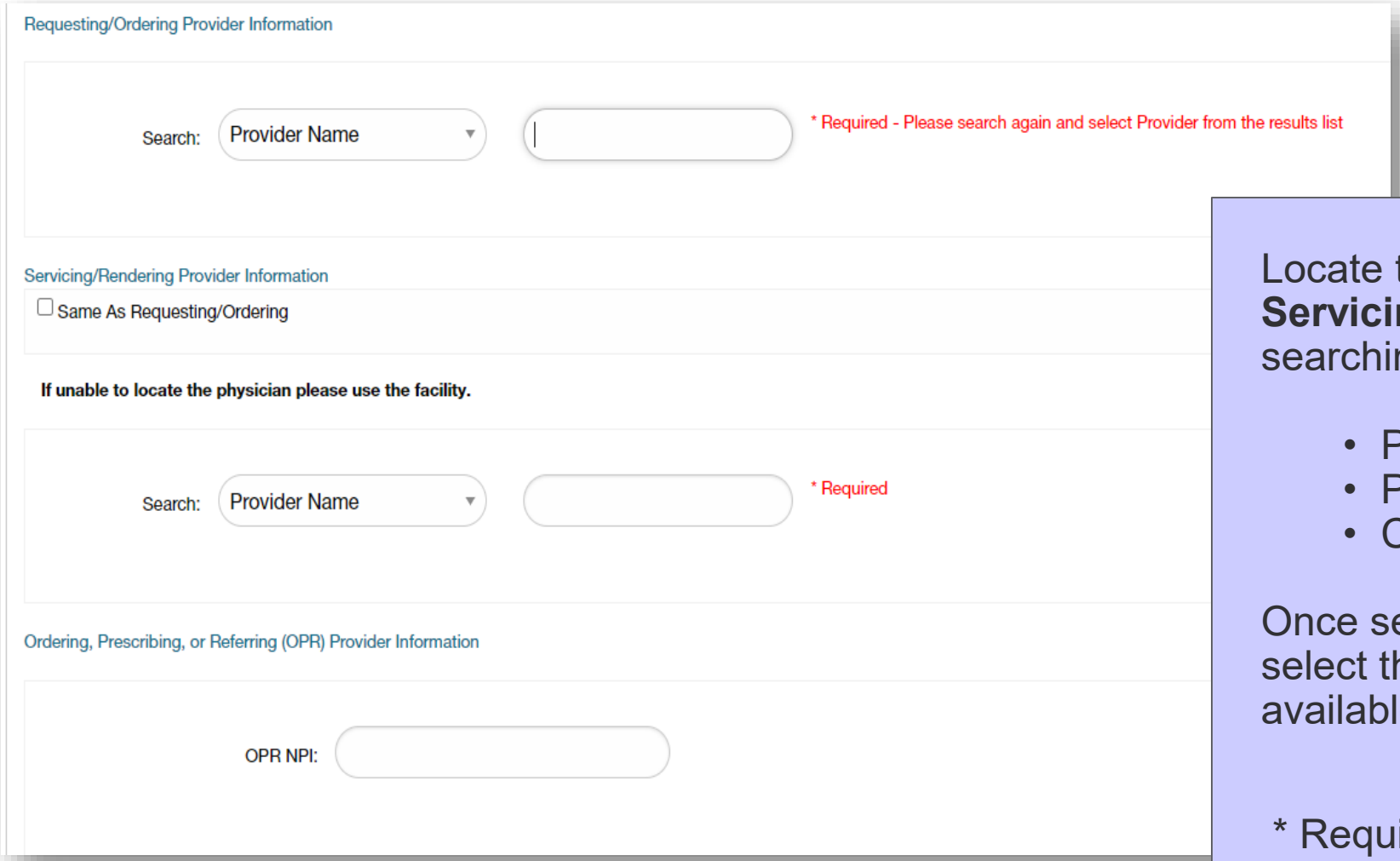
PRIOR AUTHORIZATION TYPE

Complete the authorization form by filling out the following fields:

- Select if the service is *Inpatient* or *Outpatient*.
- Select the appropriate category.
- Select the type of prior authorization request.
- Select if the service will be completed in a Facility.



PRIOR AUTHORIZATION PROVIDER INFO



Locate the **Requesting/Ordering*** and **Servicing/Rendering Provider*** by searching:

- Provider Name
- Provider NPI
- CareSource Provider ID

Once searched criteria has been entered, select the appropriate provider from the available list.

* Required Fields

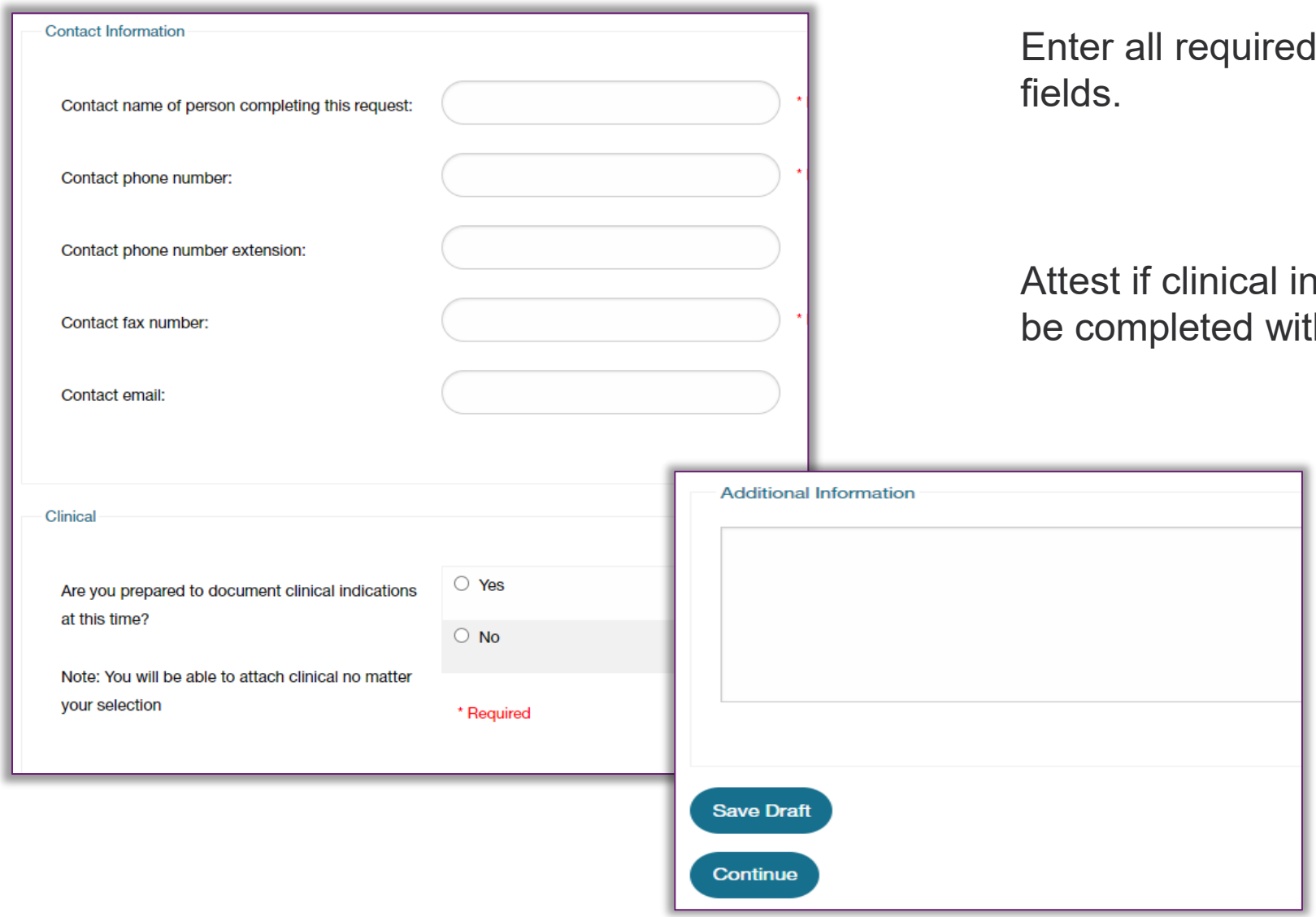
PRIOR AUTHORIZATION DETAILS

Complete the following fields:

- End Date
- Choose a Treatment Type
- Choose a Place of Service
- Enter all applicable diagnosis and procedure codes

Once a procedure code is entered, units and modifiers may be selected.

PRIOR AUTHORIZATION CONTACT INFO



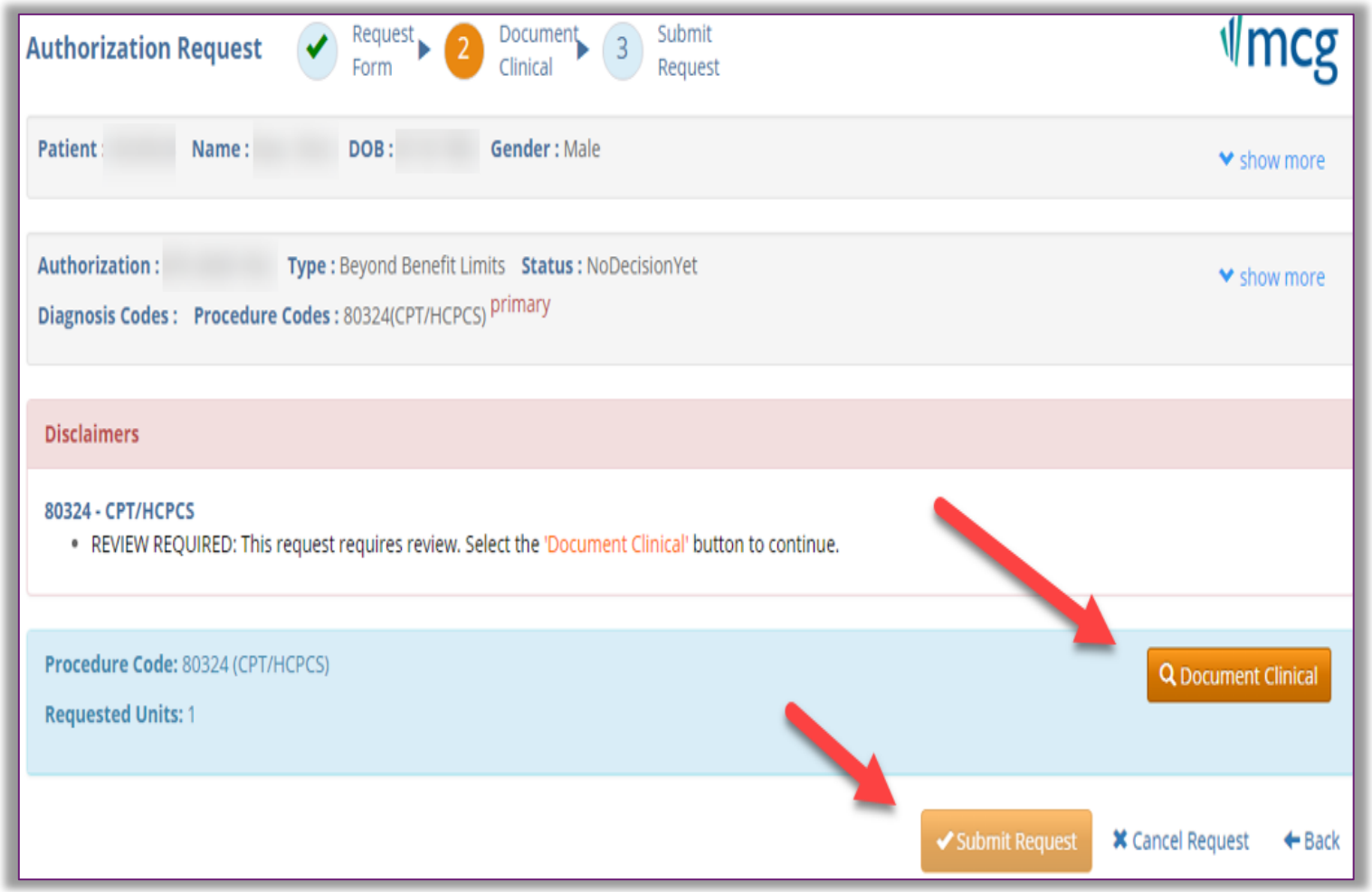
Enter all required contact information fields.

Attest if clinical information documents will be completed with any additional notes.

Click **Continue**.

A draft authorization may be saved to come back to later by clicking **Save Draft**.

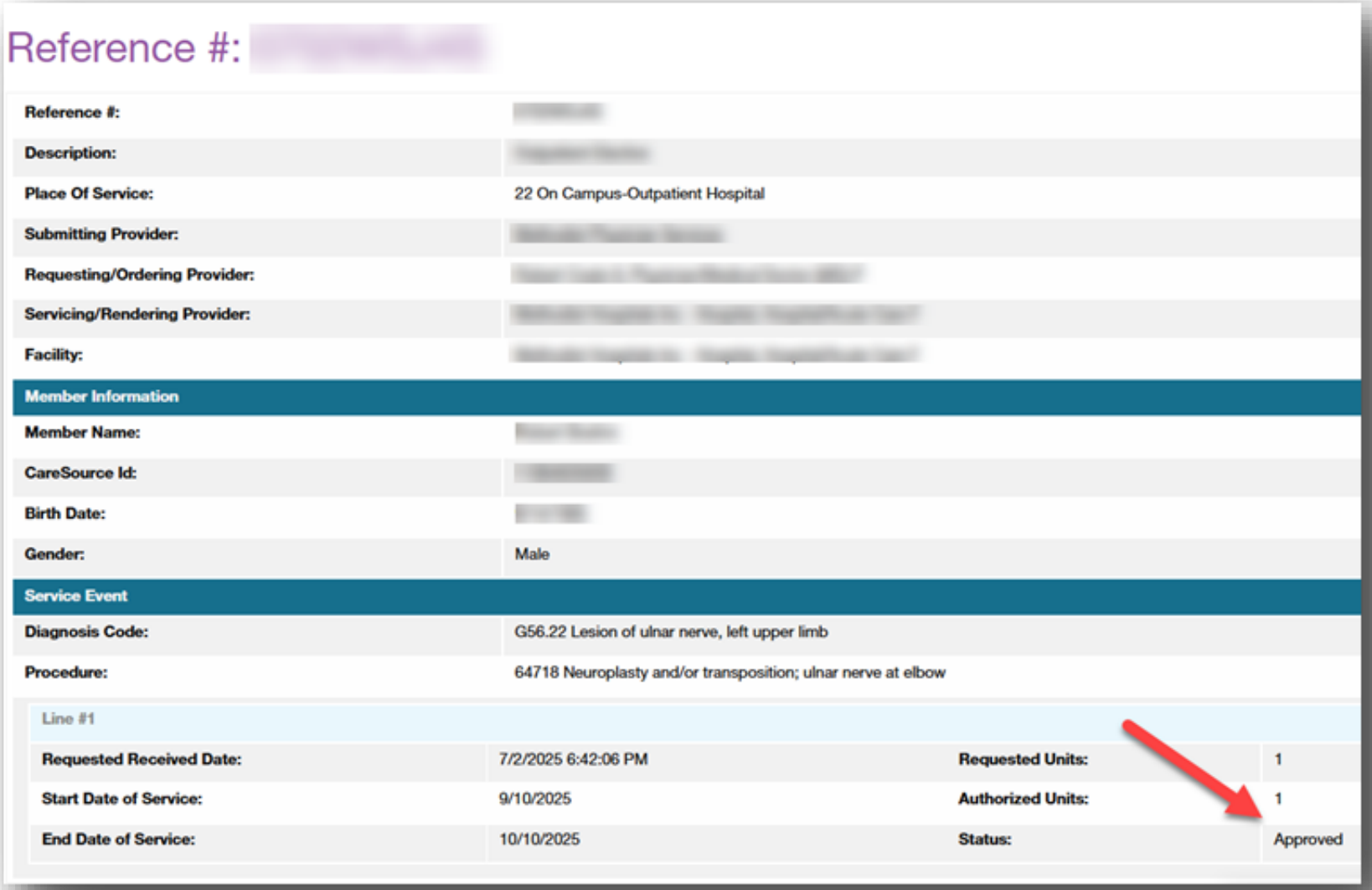
PRIOR AUTHORIZATION COMPLETION



The authorization will be processed through the Cite Auto for Milliman Care Guidelines (MCG) program.

Complete any required clinical documentation by clicking **Document Clinical** and click **Submit Request**.

PRIOR AUTHORIZATION RESPONSE



Reference #: [redacted]

Reference #:	[redacted]
Description:	[redacted]
Place Of Service:	22 On Campus-Outpatient Hospital
Submitting Provider:	[redacted]
Requesting/Ordering Provider:	[redacted]
Servicing/Rendering Provider:	[redacted]
Facility:	[redacted]

Member Information

Member Name:	[redacted]
CareSource Id:	[redacted]
Birth Date:	[redacted]
Gender:	Male

Service Event

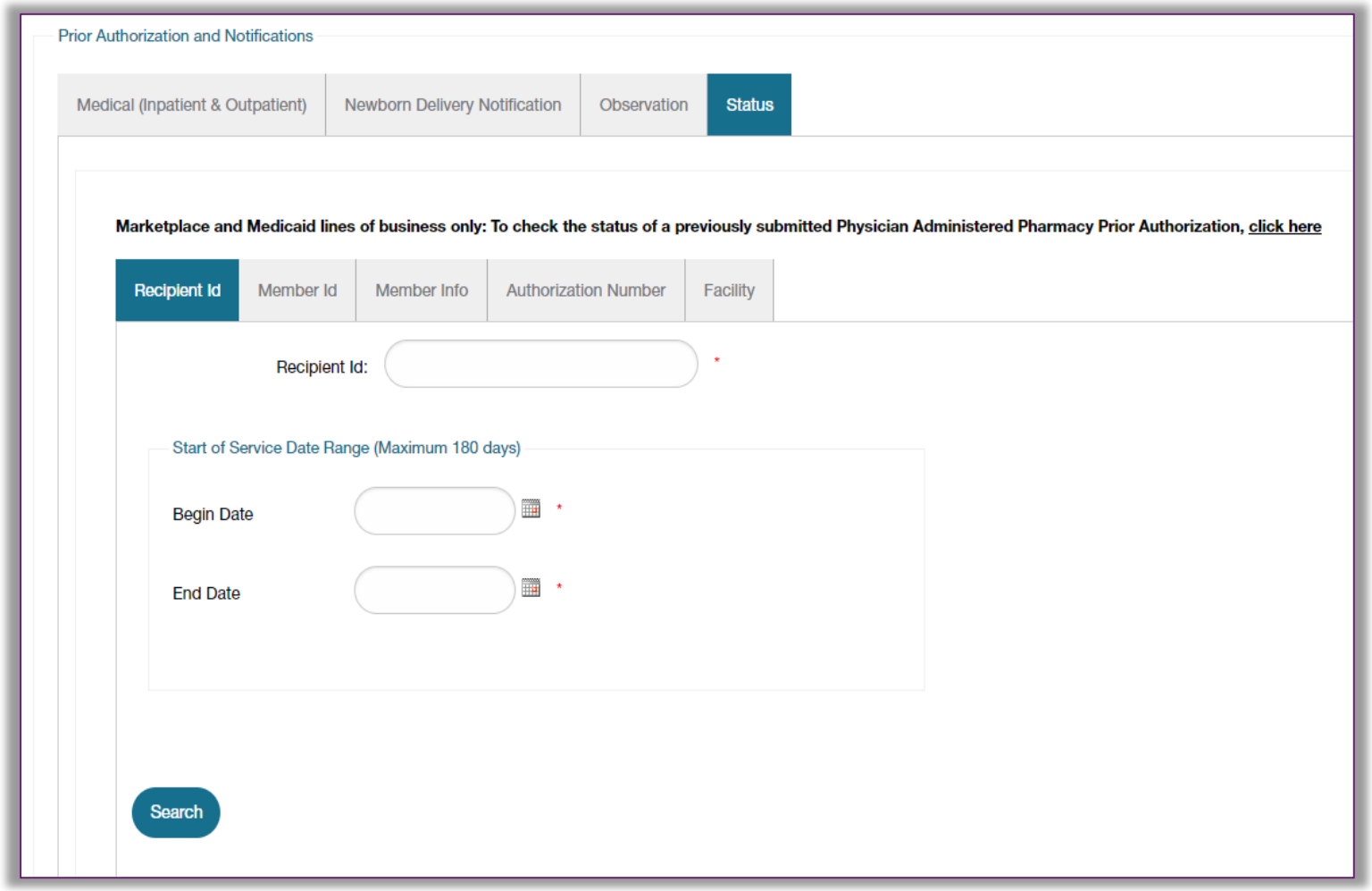
Diagnosis Code:	G56.22 Lesion of ulnar nerve, left upper limb
Procedure:	64718 Neuroplasty and/or transposition; ulnar nerve at elbow

Line #1

Requested Received Date:	7/2/2025 6:42:06 PM	**Requested Units:**	1
Start Date of Service:	9/10/2025	**Authorized Units:**	1
End Date of Service:	10/10/2025	**Status:**	Approved

The status of the authorization as well as a reference number will be provided that can be used to review status if needed later.

PRIOR AUTHORIZATION STATUS



Prior authorization status may be viewed by searching:

- Member ID
- Member Info
- Authorization Number
- Facility

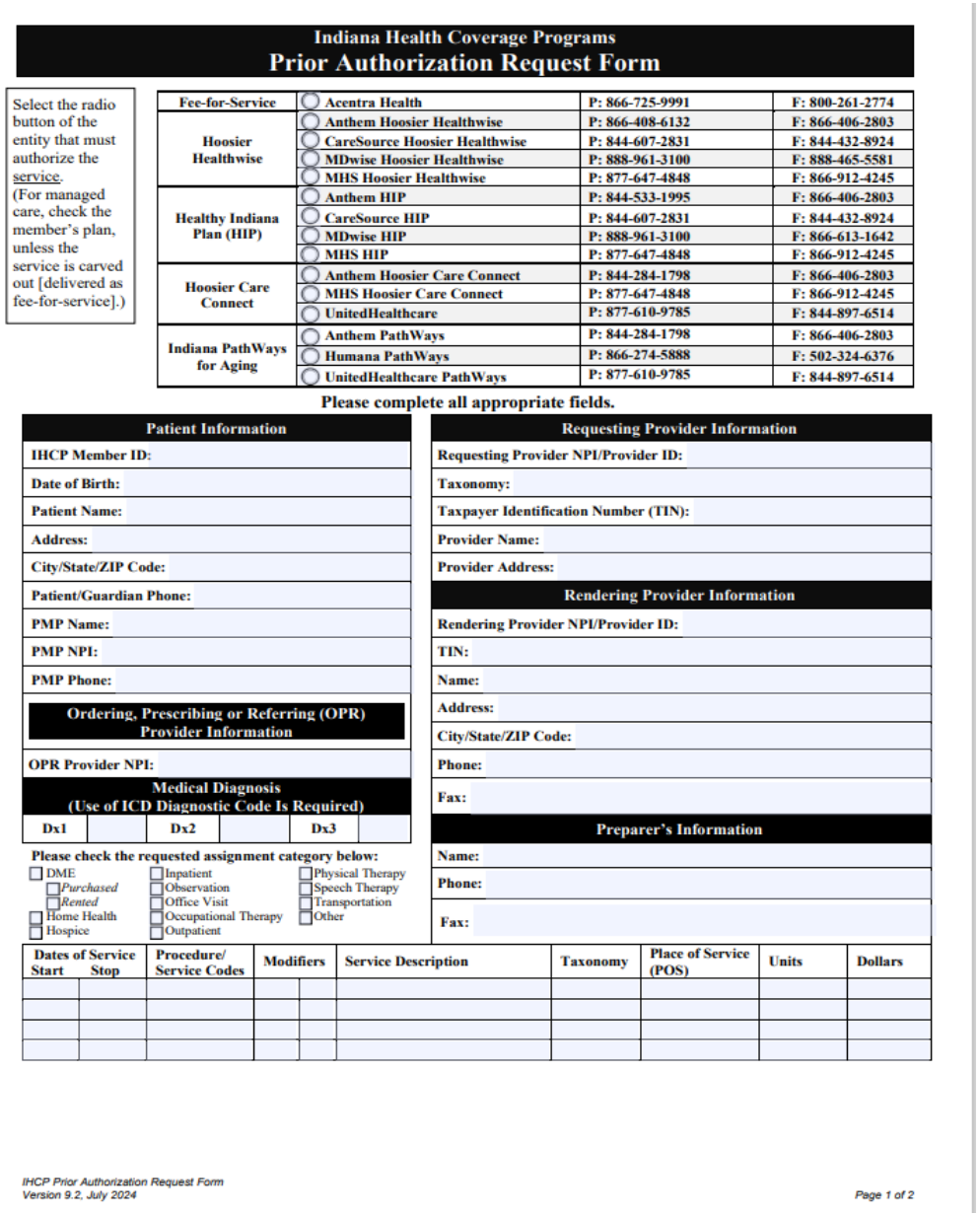
MAIL OR FAX

PRIOR AUTHORIZATION FORMS

The Prior Authorization Request Form is available on the CareSource Provider Portal under the Mail option: Prior Authorization | Indiana – Medicaid | CareSource

The form is also available on the state website:
Indiana Health Coverage Programs (IHCP) Universal Prior Authorization Request Form

Indiana Health Coverage Programs Prior Authorization Request Form Instructions



Indiana Health Coverage Programs
Prior Authorization Request Form

Select the radio button of the entity that must authorize the service. (For managed care, check the member's plan, unless the service is carved out [delivered as fee-for-service].)

Fee-for-Service	◯ Acentra Health	P: 866-725-9991	F: 800-261-2774
Hoosier Healthwise	◯ Anthem Hoosier Healthwise	P: 866-408-6132	F: 866-406-2803
	◯ CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	◯ MDwise Hoosier Healthwise	P: 888-961-3100	F: 888-465-5581
	◯ MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan (HIP)	◯ Anthem HIP	P: 844-533-1995	F: 866-406-2803
	◯ CareSource HIP	P: 844-607-2831	F: 844-432-8924
	◯ MDwise HIP	P: 888-961-3100	F: 866-613-1642
	◯ MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	◯ Anthem Hoosier Care Connect	P: 844-284-1798	F: 866-406-2803
	◯ MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245
	◯ UnitedHealthcare	P: 877-610-9785	F: 844-897-6514
Indiana PathWays for Aging	◯ Anthem PathWays	P: 844-284-1798	F: 866-406-2803
	◯ Humana PathWays	P: 866-274-5888	F: 502-324-6376
	◯ UnitedHealthcare PathWays	P: 877-610-9785	F: 844-897-6514

Please complete all appropriate fields.

Patient Information
- IHCP Member ID:
- Date of Birth:
- Patient Name:
- Address:
- City/State/ZIP Code:
- Patient/Guardian Phone:
- PMP Name:
- PMP NPI:
- PMP Phone:

Ordering, Prescribing or Referring (OPR) Provider Information
- OPR Provider NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)
Dx1 | Dx2 | Dx3

Please check the requested assignment category below:
☐ DME ☐ *Purchased* ☐ *Rented* ☐ Home Health ☐ Hospice ☐ Inpatient ☐ Observation ☐ Office Visit ☐ Occupational Therapy ☐ Outpatient ☐ Physical Therapy ☐ Speech Therapy ☐ Transportation ☐ Other

Requesting Provider Information
- Requesting Provider NPI/Provider ID:
- Taxonomy:
- Taxpayer Identification Number (TIN):
- Provider Name:
- Provider Address:

Rendering Provider Information
- Rendering Provider NPI/Provider ID:
- TIN:
- Name:
- Address:
- City/State/ZIP Code:
- Phone:
- Fax:

Preparer's Information
- Name:
- Phone:
- Fax:

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	Place of Service (POS)	Units	Dollars

IHCP Prior Authorization Request Form
Version 9.2, July 2024

Page 1 of 2

TIMEFRAMES AND UPDATES

PRIOR AUTHORIZATION TIMEFRAMES

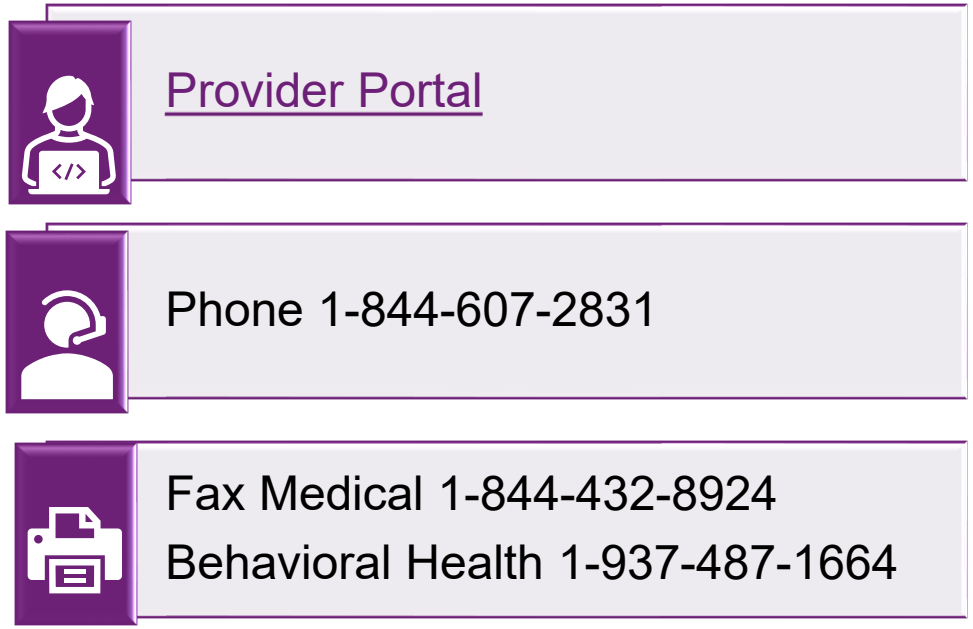
Authorization Type	Decision	Extension
Standard Pre-Service	Forty-eight (48) business hours* *Excludes weekends and holidays*	Fourteen (14) calendar days
Urgent Pre-Service	Twenty-four (24) business hours* *Excludes weekends and holidays*	Fourteen (14) calendar days
Urgent Concurrent	Forty-eight (48) hours	No extension
Post-Service (Retrospective Review)	Thirty (30) calendar days	No extension
Approved Authorization	Valid for 365 calendar days	N/A

*Updated July 1st, 2025

To check the status of a prior authorization request call **844-607-2831** or log into the Provider Portal.

UPDATING AN APPROVED PRIOR AUTHORIZATION SUBMISSION

Any changes to an existing prior authorization must be submitted to CareSource:



Example of Changes

- Current Procedural Terminology (CPT) and/or Healthcare Common Procedure Coding System (HCPCS) codes
- Rendering provider
- Location of service
- Dates of service
- Units (service and/or medication)

COORDINATION OF BENEFITS (COB)

When a member has a Primary Payer and CareSource as secondary coverage.

If CareSource requires a prior authorization for a service:

Provider must follow the **primary** insurers requirements and obtain prior authorization.

Provider must obtain prior authorization from **CareSource** when primary payer's authorization was denied partially or in full.*

*When submitting a request to CareSource, include the primary payer's authorization denial and/or the primary payers EOP denial.

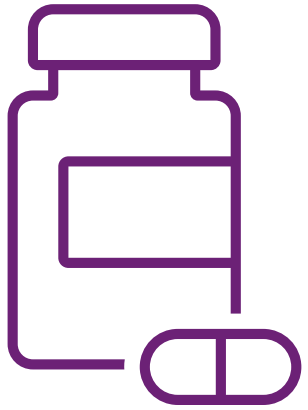
SPECIAL SERVICES

PRIOR AUTHORIZATION PHARMACY

Some drugs may require prior authorization. Refer to the Pharmacy page to review these requirements.

For drugs processed through the **medical benefit**, refer to the Procedure Code Lookup Tool and Authorization Requirements for Medications Under the Medical Benefit under Prior Authorization.

For drugs processed through Express Scripts, refer to the Formulary or Preferred Drug List (PDL) on the Drug Formulary page.



For Outpatient Prior Authorization for Physician Administered Pharmacy Codes see additional information at Submitting Outpatient Prior Authorization for Physician Administered Pharmacy Codes

EVOLENT (FORMERLY NIA/MAGELLAN)

CareSource partners with Evolent to implement our radiology benefit management program for outpatient advanced imaging services.

Procedures which require prior authorization through Evolent:

Refer to the **Procedure Code Lookup Tool** to determine services authorized by Evolent

Services which do not require prior authorization through Evolent:

Inpatient Advanced Imaging Services

Observation

Emergency room imaging services

Evolent Authorization phone and website information:

1-800-424-4883
8am – 8pm

Welcome to RadMD.com | RADMD
Urgent/Expedited authorizations – contact the Provider Support Team

DENTAL

DENTAL MANUAL

The Dental Provider Office Reference Manual (ORM) is a comprehensive resource for our dental providers and serves as a link between your office and CareSource. It includes important information on topics such as covered services, services that require prior authorization, claim submission, and much more.

Dental services may require PA for specific age groups.

Some services may require post treatment/prepayment review.

Any unspecified services by report require prior authorization.

The Dental Office Reference Manual (ORM) should be consulted for specific prior authorization requirements.

DENTAL SERVICES THAT REQUIRE PRIOR AUTHORIZATION (PA)

- Periodontal Surgery and some Endodontic Surgery
- Space maintenance for children under 3 years of age or if permanent teeth are missing
- Dentures (complete and partial)
- Sleep Apnea Appliances
- Some Frenectomy and Corticotomy Procedures
- General anesthesia and sedation ≥ Age 21
- Repairs and relines of dentures (complete and partial) for members ≥ Age 21
- Orthodontics

HOW TO SUBMIT DENTAL PRIOR AUTHORIZATION

Online

Dental health partners may submit prior authorizations online at Landing (sciondental.com).

Paper

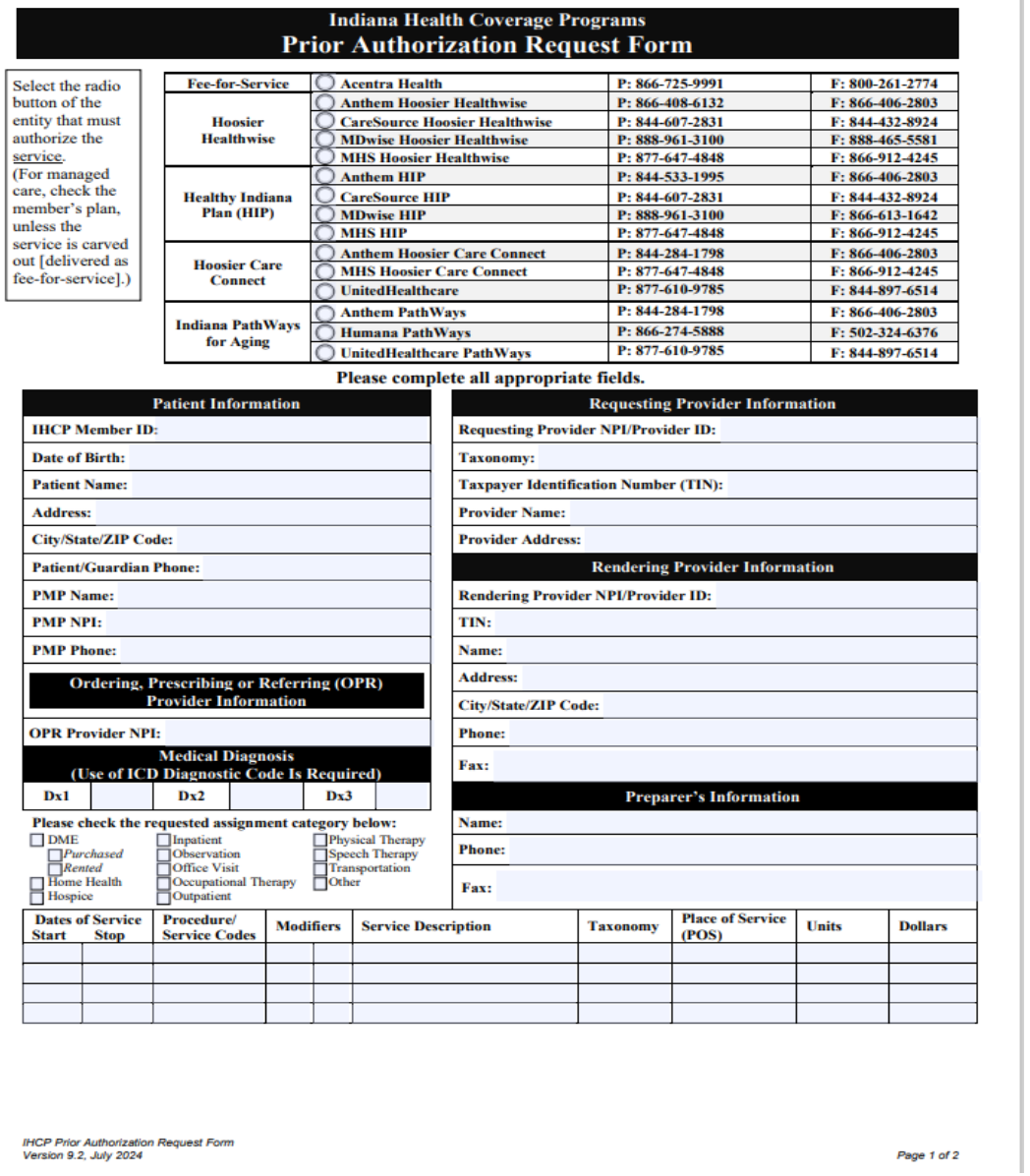
CareSource IN: Authorizations
P.O. Box 745
Milwaukee, WI 53201

Contact CareSource Health Partner Services at **1-844-607-2831** (Monday to Friday 8 a.m. to 8 p.m. (EST)) for any questions regarding prior authorizations.

BEHAVIORAL HEALTH

BEHAVIORAL HEALTH (BH) PA LIST

- Applied Behavioral Analysis (ABA therapy)
- Psychiatric inpatient admissions, including admissions for substance use and rehabilitation
- Medicaid Rehabilitation Option (MRO) services, except for crisis intervention
- Partial Hospitalization Program (PHP) services
- Intensive Outpatient Treatment (IOT)



Indiana Health Coverage Programs
Prior Authorization Request Form

Select the radio button of the entity that must authorize the service. (For managed care, check the member's plan, unless the service is carved out [delivered as fee-for-service].)

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Hoosier Healthwise	Anthem Hoosier Healthwise	P: 866-408-6132	F: 866-406-2803
	CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	MDwise Hoosier Healthwise	P: 888-961-3100	F: 888-465-5581
	MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan (HIP)	Anthem HIP	P: 844-533-1995	F: 866-406-2803
	CareSource HIP	P: 844-607-2831	F: 844-432-8924
	MDwise HIP	P: 888-961-3100	F: 866-613-1642
	MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	Anthem Hoosier Care Connect	P: 844-284-1798	F: 866-406-2803
	MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245
	UnitedHealthcare	P: 877-610-9785	F: 844-897-6514
Indiana PathWays for Aging	Anthem PathWays	P: 844-284-1798	F: 866-406-2803
	Humana PathWays	P: 866-274-5888	F: 502-324-6376
	UnitedHealthcare PathWays	P: 877-610-9785	F: 844-897-6514

Please complete all appropriate fields.

Patient Information
IHCP Member ID:
Date of Birth:
Patient Name:
Address:
City/State/ZIP Code:
Patient/Guardian Phone:
PMP Name:
PMP NPI:
PMP Phone:

Ordering, Prescribing or Referring (OPR) Provider Information
OPR Provider NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)
Dx1 | Dx2 | Dx3

Requesting Provider Information
Requesting Provider NPI/Provider ID:
Taxonomy:
Taxpayer Identification Number (TIN):
Provider Name:
Provider Address:

Rendering Provider Information
Rendering Provider NPI/Provider ID:
TIN:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:

Preparer's Information
Name:
Phone:
Fax:

Please check the requested assignment category below:
DME (Purchased, Rented) | Home Health | Hospice | Inpatient | Observation | Office Visit | Occupational Therapy | Outpatient | Physical Therapy | Speech Therapy | Transportation | Other

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	Place of Service (POS)	Units	Dollars

IHCP Prior Authorization Request Form
Version 9.2, July 2024
Page 1 of 2

IHCP Universal Prior Authorization Request Form

BH PA REMINDERS

We would like to remind our behavioral health providers of the billing requirements that for certain psychiatric codes in combination are subject to 20 units per member, per provider, per rolling 12-month period, without a PA.

- Psychiatric services that include covered codes within the CPT range 90785-90899

One unit of psychiatric diagnostic interview examinations per member, per provider, per rolling 12-month period, billed using one of the following CPT codes:

- 90791 – Psychiatric diagnostic evaluation
- 90792 – Psychiatric diagnostic evaluation with medical services

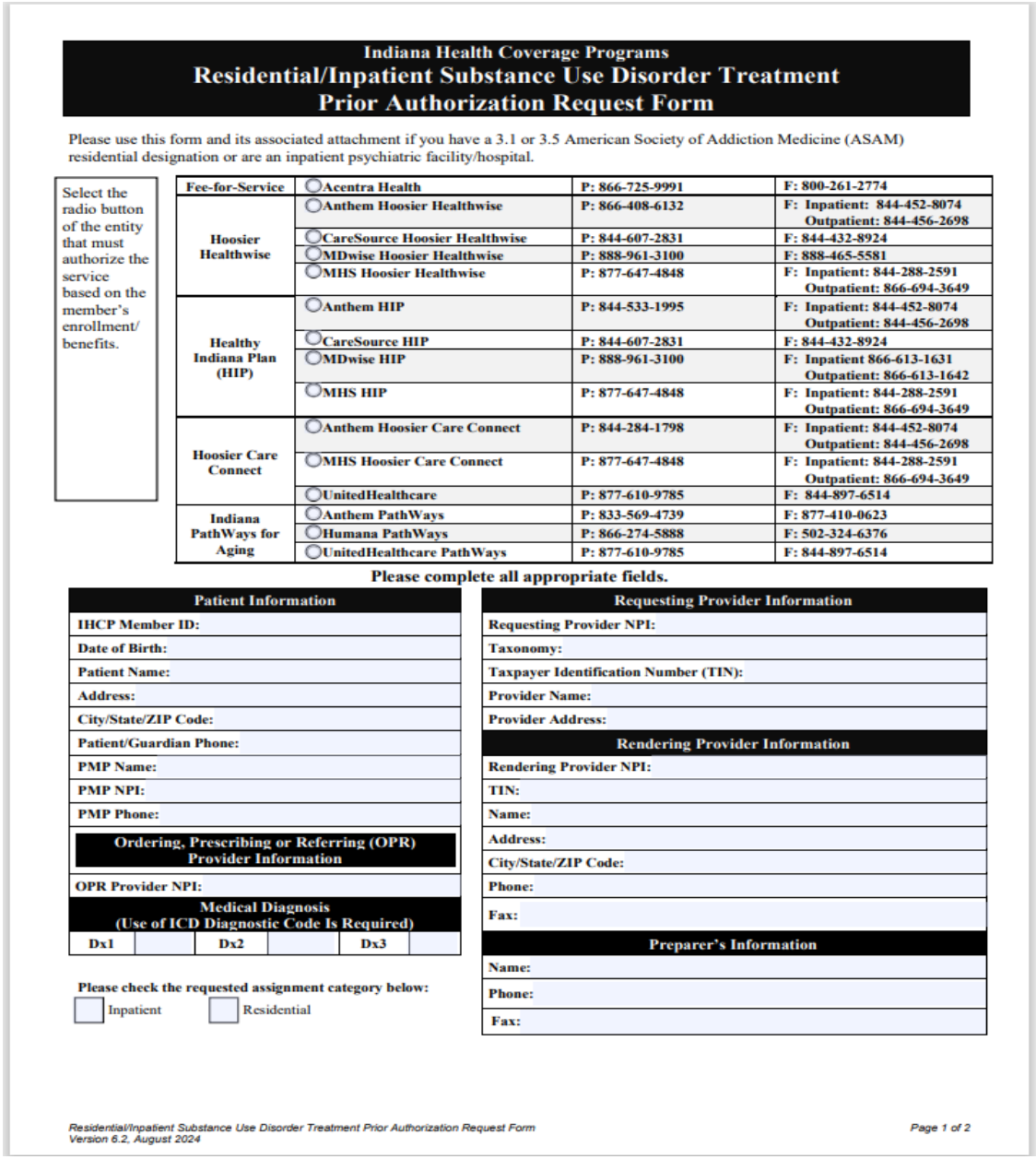
SUBSTANCE USE DISORDER (SUD) PRIOR AUTHORIZATION REQUEST FORM

Include the Initial Assessment form and reassessment form when requesting SUD PAs.

The rendering provider is the facility when requesting these services, as specialty type 836 is a billing provider.

All requests must have current American Society of Addiction Medicine (ASAM) documentation within fourteen (14) calendar days of the requested date of service. Concurrent requests should be submitted in increments of seven (7) calendar days.

The SUD Universal Standard PA form is located on CareSource's Forms page here: Forms | Indiana – Medicaid | CareSource



Indiana Health Coverage Programs
Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form

Please use this form and its associated attachment if you have a 3.1 or 3.5 American Society of Addiction Medicine (ASAM) residential designation or are an inpatient psychiatric facility/hospital.

Select the radio button of the entity that must authorize the service based on the member's enrollment/ benefits.

Fee-for-Service	◯ Acentra Health	P: 866-725-9991	F: 800-261-2774
Hoosier Healthwise	◯ Anthem Hoosier Healthwise	P: 866-408-6132	F: Inpatient: 844-452-8074 Outpatient: 844-456-2698
	◯ CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	◯ MDwise Hoosier Healthwise	P: 888-961-3100	F: 888-465-5581
	◯ MHS Hoosier Healthwise	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
Healthy Indiana Plan (HIP)	◯ Anthem HIP	P: 844-533-1995	F: Inpatient: 844-452-8074 Outpatient: 844-456-2698
	◯ CareSource HIP	P: 844-607-2831	F: 844-432-8924
	◯ MDwise HIP	P: 888-961-3100	F: Inpatient 866-613-1631 Outpatient: 866-613-1642
	◯ MHS HIP	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
Hoosier Care Connect	◯ Anthem Hoosier Care Connect	P: 844-284-1798	F: Inpatient: 844-452-8074 Outpatient: 844-456-2698
	◯ MHS Hoosier Care Connect	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
	◯ UnitedHealthcare	P: 877-610-9785	F: 844-897-6514
Indiana PathWays for Aging	◯ Anthem PathWays	P: 833-569-4739	F: 877-410-0623
	◯ Humana PathWays	P: 866-274-5888	F: 502-324-6376
	◯ UnitedHealthcare PathWays	P: 877-610-9785	F: 844-897-6514

Please complete all appropriate fields.

Patient Information
IHCP Member ID:
Date of Birth:
Patient Name:
Address:
City/State/ZIP Code:
Patient/Guardian Phone:
PMP Name:
PMP NPI:
PMP Phone:
Ordering, Prescribing or Referring (OPR) Provider Information
OPR Provider NPI:
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)
Dx1 | Dx2 | Dx3

Requesting Provider Information
Requesting Provider NPI:
Taxonomy:
Taxpayer Identification Number (TIN):
Provider Name:
Provider Address:
Rendering Provider Information
Rendering Provider NPI:
TIN:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:
Preparer's Information
Name:
Phone:
Fax:

Please check the requested assignment category below:
☐ Inpatient ☐ Residential

Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form
Version 6.2, August 2024
Page 1 of 2

RETRO-AUTHORIZATION

MEDICAID RETRO AUTHORIZATIONS GUIDELINES

Upon written request, CareSource shall not permit retro authorization submission after the date of service or admission where a prior authorization was required but not obtained except in the following circumstances as outlined in the IHCP Provider Reference Module for Prior Authorization.

RETRO AUTHORIZATIONS

Prior Authorization will be given after services have begun or supplies have been delivered only under the following circumstances:

Pending or retroactive member eligibility. The prior authorization request must be submitted within twelve (12) months of the date when the member's caseworker entered the eligibility information.

Mechanical or administrative delays or errors by the contractor or county office of Family and Social Services Administration (FSSA) Division of Family Resources (DFR).

Services rendered outside Indiana by a provider that had not yet enrolled as an IHCP provider.

Transportation services to or from an out-of-state area or rendered by a provider located out of state or by an airline or air ambulance. The prior authorization request must be submitted within twelve (12) months of the date of service.

MEDICAID RETRO AUTHORIZATIONS – UNAWARE OF COVERAGE

The provider was unaware that the member was eligible for services at the time services were rendered.

Prior authorization will be granted in this situation only if the following conditions are met:

- The provider's records document that the member refused or was physically unable to provide the IHCP Member ID (MID) number.
- The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.
- The provider submitted the request for prior authorization within sixty (60) calendar days of the date Medicaid eligibility was discovered.

RETRO AUTHORIZATION TIMEFRAMES

Retrospective (post-service) reviews will be decided within **30 calendar days** from the receipt of the request.

If a provider's service changes during a procedure, you must call or fax CareSource immediately to seek a change in your Prior Authorization or request a retro auth if the original service did not require one.

PEER-TO-PEER REVIEW

Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations.
If you would like to discuss a case with the Clinical Peer Reviewer, please contact the Utilization Management Department.

By Phone at **1-844-607-2831 ext. 1283**

By Fax at **1-844-432-8924**

You must contact CareSource within **seven (7)** business days of the determination.

Our new line was created with a special team dedicated to answer live calls. You will be able to reach a live staff member anytime during hours of 8 am to 5 pm EST.

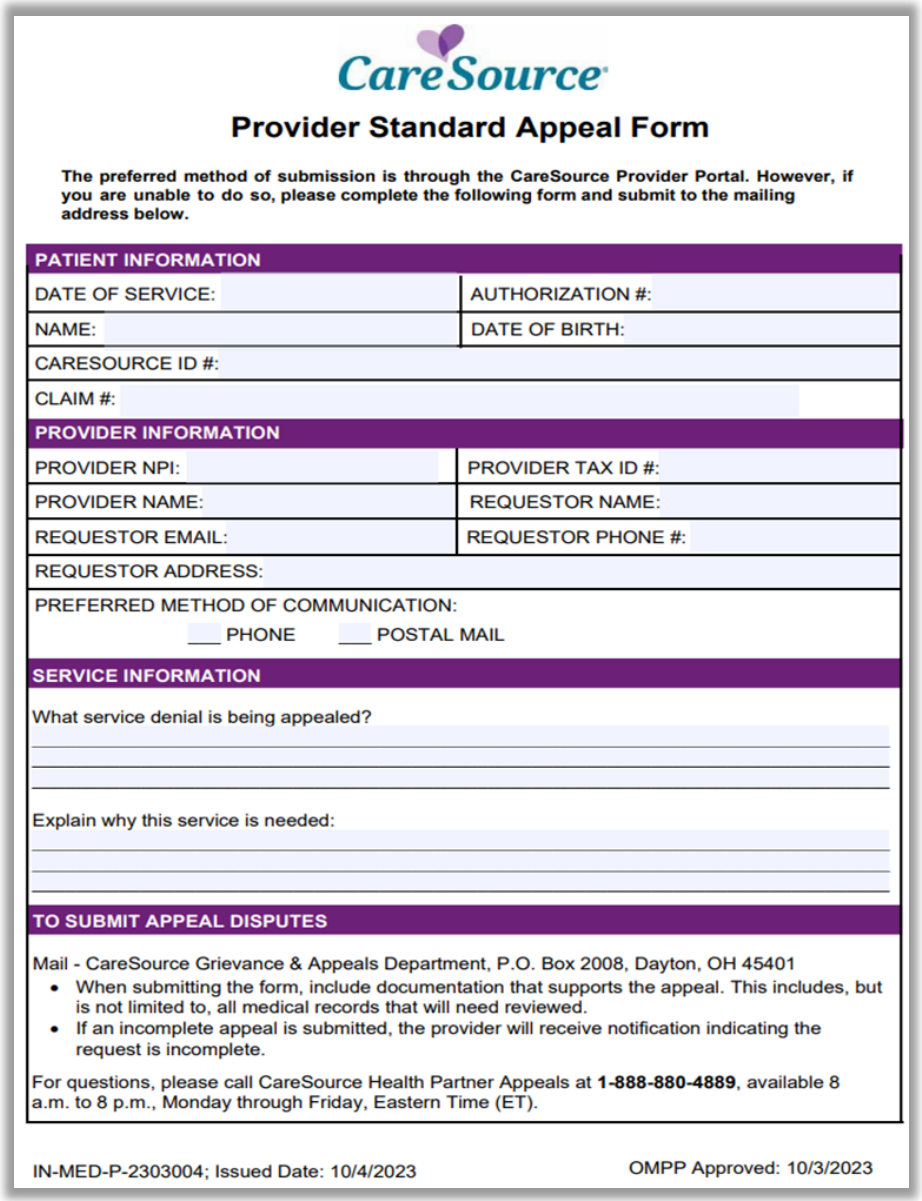
CareSource Indiana Provider Manual > Utilization Management

APPEAL PROCESS

ADMINISTRATIVE DENIALS

- Late notification of inpatient admission
- Member not eligible at time of request for authorization
- Late Retro Physician Denial
- Non-Covered Codes

PROVIDER STANDARD APPEAL FORM



CareSource

Provider Standard Appeal Form

The preferred method of submission is through the CareSource Provider Portal. 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 #:
NAME:	DATE OF BIRTH:
CARESOURCE ID #:	
CLAIM #:	

PROVIDER INFORMATION	
PROVIDER NPI:	PROVIDER TAX ID #:
PROVIDER NAME:	REQUESTOR NAME:
REQUESTOR EMAIL:	REQUESTOR PHONE #:
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 DISPUTES

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

- When submitting the form, include documentation that supports the appeal. This includes, but is not limited to, all medical records that will need reviewed.
- If an incomplete appeal is submitted, the provider will receive notification indicating the request is incomplete.

For questions, please call CareSource Health Partner Appeals at **1-888-880-4889**, available 8 a.m. to 8 p.m., Monday through Friday, Eastern Time (ET).

IN-MED-P-2303004; Issued Date: 10/4/2023 OMPP Approved: 10/3/2023

Providers and members can submit a pre-service or post-service clinical appeal if they disagree with a clinical decision regarding medical necessity.

The preferred method for providers to submit appeal is on the CareSource Provider portal.

- Provider Portal for Appeals (Select Clinical Appeals)

For those who do not have access to the provider portal, they can complete the Provider Standard Appeal Form.

Mail to:
CareSource Grievance & Appeals Department
P.O. Box 2008
Dayton, OH 45401

SERVICE DENIAL

PRE-SERVICE DENIAL	POST-SERVICE DENIAL
You have 60 calendar days from the date of action notice to submit a pre-service appeal. The standard decision time frame is 30 calendar days from the date of receipt by CareSource. A 14 alendar day extension may be requested by CareSource.	You have 60 calendar days from the date of action notice, discharge or authorization-denial to submit a post-service appeal. Member consent is required for post-service requests. The standard decision time frame is 30 calendar days from the date of receipt by CareSource.

EXPEDITED AUTHORIZATION APPEALS

If a provider feels that a patient's life or health is at risk if a decision about care is not made in a timely manner, you may ask CareSource to expedite a clinical appeal.

Contact Provider Services at **1-844-607-2831** to expedite a clinical appeal.

Expedited appeals will be resolved, and a verbal notification will be made within **48 hours**.

CareSource will decide whether to expedite an appeal within **24 hours**.

HOW TO CONTACT CARESOURCE

Communicating with CareSource

Provider Services	1-844-607-2831
Hours	Monday – Friday 8 am to 8 pm Eastern Time (ET)

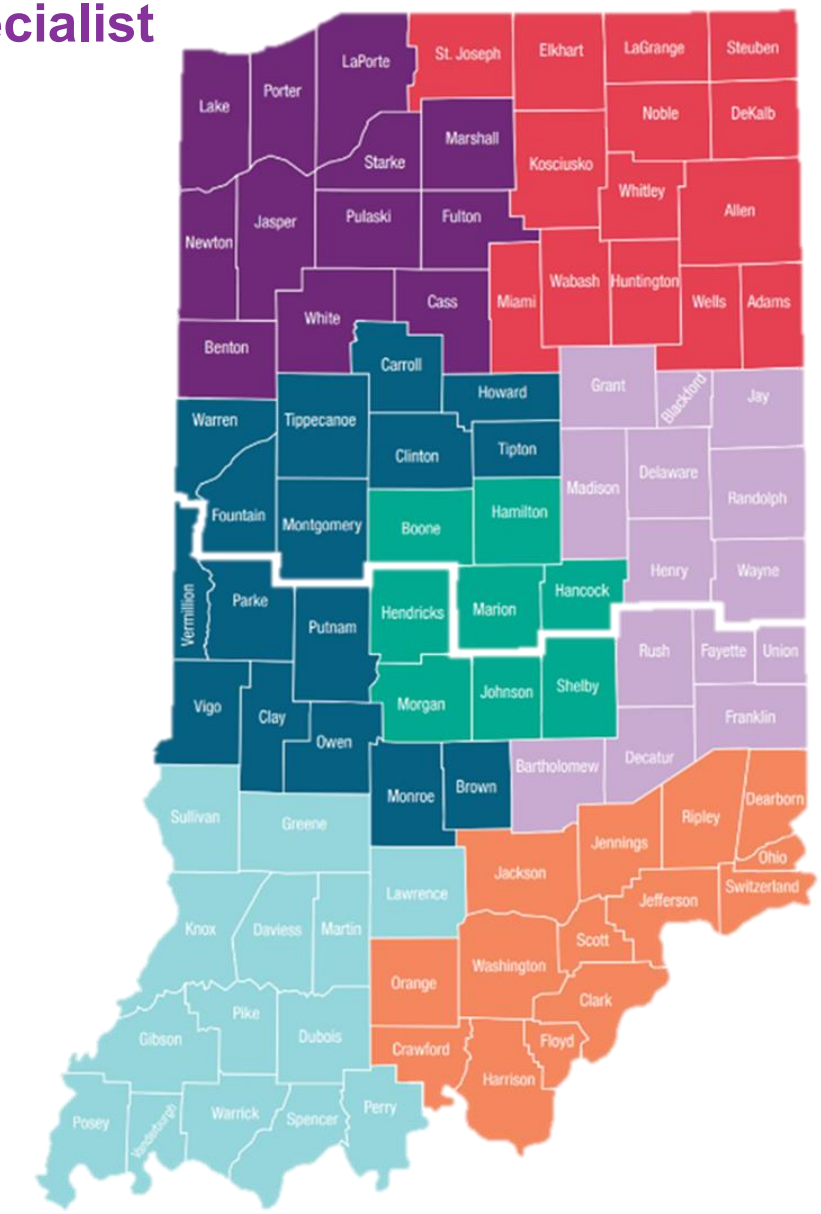
Member Services	1-844-607-2829
Hours	Monday – Friday 8 am to 8 pm Eastern Time (ET)

Health Partner Engagement Representatives – Regional Specialist

Tammy Garrett
219-221-7065
Tammy.Garrett@CareSource.com
Franciscan Alliance, Fresenius (Statewide)

Amy Dagon
317-417-9652
Amy.Dagon@CareSource.com
Community Health Network, Union Hospital, American Health Network

Paula Egan
812-447-6661
Paula.Egan@CareSource.com
Deaconess, Ascension – St. Vincent Health



Leigh Hoover
765-425-0462
Leigh.Hoover@CareSource.com
Parkview, Lutheran, St. Joseph Regional Medical Center, Beacon

Francesca Mekos
317-982-0423
Francesca.Mekos@CareSource.com
Eskenazi, Reid Health

Sarah Tinsley
317-607-4844
Sarah.Tinsley@CareSource.com
Indiana University, Suburban Health Organization

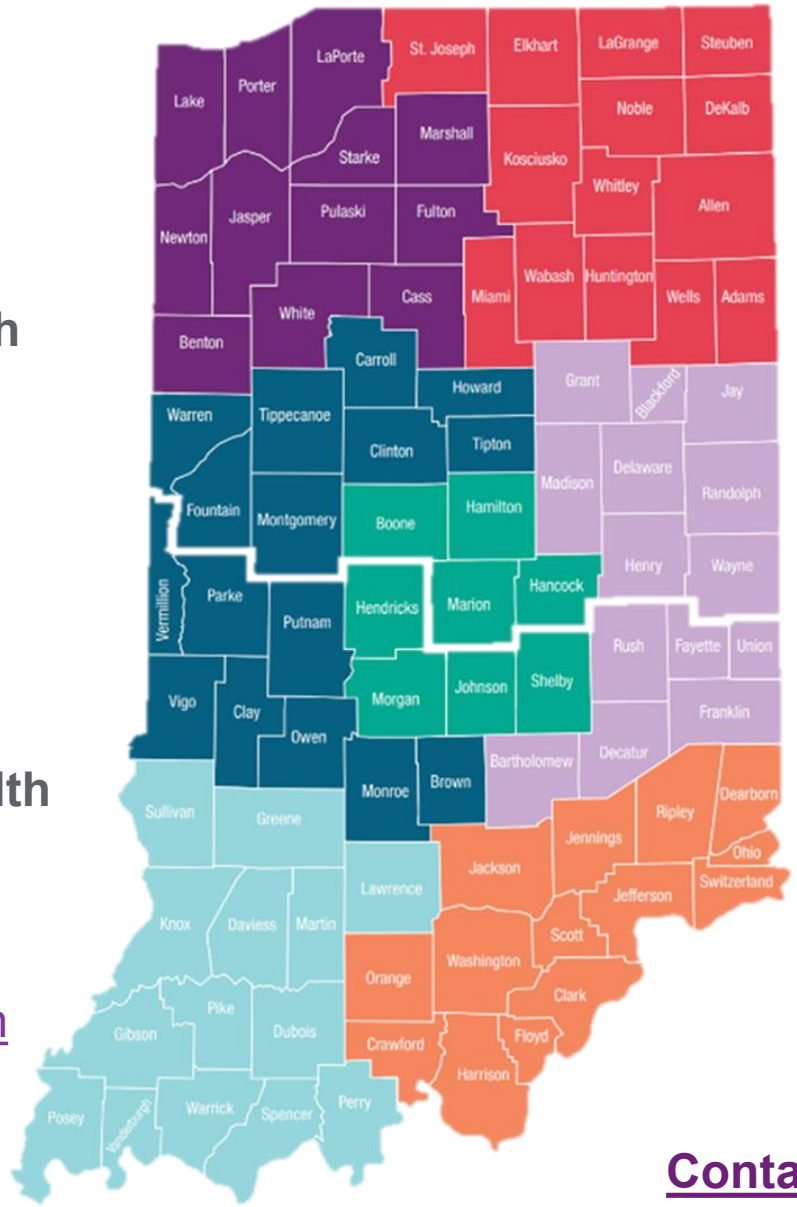
Bonnie Waelde
812-480-9203
Bonnie.Waelde@CareSource.com
University of Louisville, Norton, Baptist Health Floyd, ATI Physical Therapy (Statewide)

Contact Us | Indiana – Medicaid | CareSource

Health Partner Engagement Representatives – **Behavioral Health**

Amanda Denny, Behavioral Health
Resolution Specialist (Northern Territory)
765-620-6722
Amanda.Denny@CareSource.com

Stephanie Gates, Behavioral Health
Resolution Specialist (Southern Territory)
317-501-6380
Stephanie.Gates@CareSource.com



Contracting Managers – **Hospitals/Large Health Systems**

Maria Crawford (Northern Territory) 317-416-6854
Maria.Crawford@CareSource.com

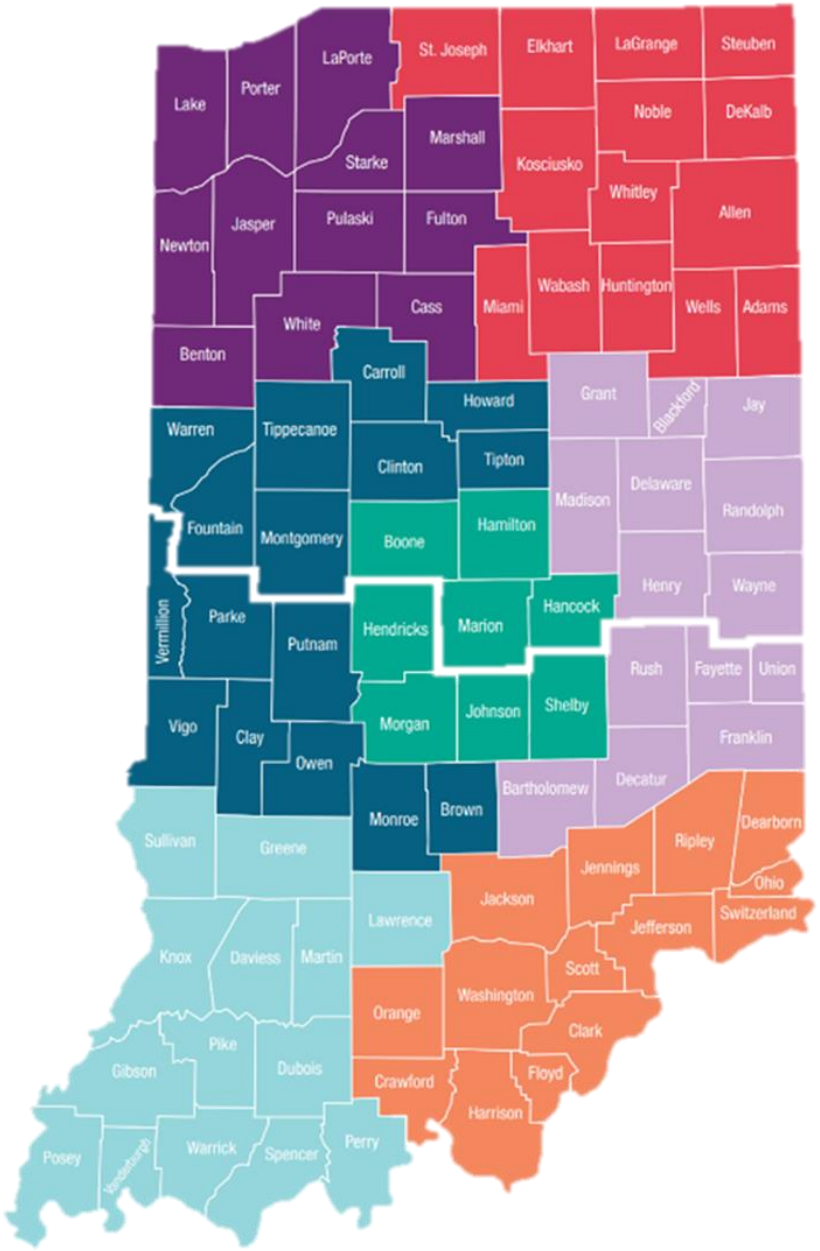
Sara Culley (Southern Territory)
765-256-0423
Sara.Culley@CareSource.com

Contact Us | Indiana – Medicaid | CareSource

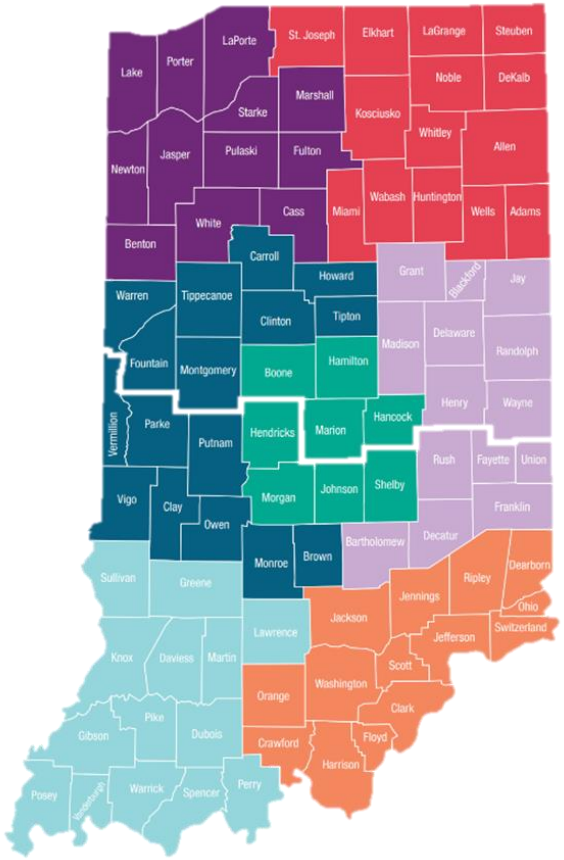
Health Partner Engagement Representatives – **Manager**

Amy Williams
Manager Health Partnerships
317-741-3347
Amy.Williams@CareSource.com

Contact Us | Indiana – Medicaid | CareSource



SCAN FOR A COPY OF THE HP ENGAGEMENT SPECIALIST MAP



SCAN ME

CARESOURCE.COM

Thank you for attending!

By taking a few moments to complete the event and session evaluations, you help us understand your experience and shape the future of our programs.

gainwell

IN-MED-P-4512305; Issue Date: 9/16/2025

OMPP Approved: 9/16/2025