Provider Payment Dispute and Correspondence – Submission Form

This form should be completed by providers for payment disputes and claim correspondence only.

Member First/Last Name_____ Member Date of Birth _____
Member Amerigroup, Medicaid or Medicare ID # (circle one) _____
Provider First/Last Name_____ National Provider Identification (NPI) #_____

☐ I am a participating provider. ☐ I am a nonparticipating* provider.

*If filing for a Medicare member and the member has potential financial liability, you must include a completed Centers for Medicare & Medicaid Services (CMS) Waiver of Liability form.

Provider Contact First/Last Name_____ Contact Phone (____) _____ _____
Provider Street Address_____
City_____ State_____ ZIP_____ Phone (_____) _____
Claim #_____ Billed Amount $_____ Amount Received $_____
Start Date of Service _____ End Date of Service _____ Authorization Number_____

To ensure timely and accurate processing of your request, please complete the Payment Dispute or Claim Correspondence section below by checking the applicable determination or request reason that was provided on the Amerigroup determination letter or Explanation of Payment (EOP).

PAYMENT DISPUTE
A payment dispute is defined as a dispute between the provider and Amerigroup in reference to a claim determination where the member cannot be held financially liable. All disputes with member liability must
follow the applicable appeals process. Please refer to the EOP to ensure you are following the correct process.

Check the appropriate dispute type below:
(☐) **First-level dispute**
(☐)**Second-level dispute**

Clearly and completely indicate the payment dispute reason(s) in the space provided. You may attach an additional sheet if necessary. Please include appropriate medical records.

_____
_____

CLAIM CORRESPONDENCE
Claim correspondence is defined as a request for additional/needed information in order for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

Check the appropriate box below.
(☐) **Itemized Bill/Medical Records (in response to an Amerigroup claim denial or request)**
(☐) **Corrected Claim Other Insurance/Third-Party Liability Information/Other Correspondence**

Clearly and completely indicate the reason(s) for your correspondence. You may attach an additional sheet if necessary.

_____

Mail this form and supporting documentation to:

Payment Disputes
Amerigroup
P.O. Box 61599
Virginia Beach, VA 23466-1599