Claim Payment Appeal – Submission Form

This form should be completed by providers for payment appeals only.

Member Information:

Member First/Last Name: _____ Member Date of Birth: _____

Member Coverage: ☐ Medicaid Member ID: _____

Provider/Provider Representative Information:

Provider First/Last Name: _____ NPI Number: _____

Provider Street Address: _____

City: _____ State: _____ ZIP Code: _____

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

Provider Representative: ☐ Self ☐ Billing Agency ☐ Law Firm ☐ Other: _____

Representative Contact Name: _____ Contact Phone: (_____) _____

Representative Street Address: _____ Email: _____

City: _____ State: _____ ZIP Code: _____

Claim Information:**

Claim Number: _____ Billed Amount: $_____ Amount Received: $_____

Start Date of Service: _____ End Date of Service: _____ Authorization Number: _____

** If you have multiple claims related to the same issue, you can use one form and attach a listing of the claims with each supporting document following behind.

Payment Appeal

A payment appeal is defined as a request from a health care provider to change a decision made by Amerigroup related to claim payment for services already provided. A provider payment appeal is **not** a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a notice of action.

☐ First-level Appeal ☐ Second-level Appeal (Not available in Ohio)

To ensure timely and accurate processing of your request, please complete the Payment Dispute section below by checking the applicable determination provided on the Amerigroup determination letter or Explanation of Payment.

☐ Untimely filing
☐ No authorization
☐ Denied for Other Health Insurance (OHI), but member doesn't have OHI
☐ Experimental/investigational procedure denial
☐ Claim code editing denial
☐ Retrospective authorization issue
☐ Disagree that you were paid according to your contract
☐ Data elements on the claim on file does not match the claim originally submitted
☐ Denied as duplicate
☐ Denial related to provider data issue
☐ Member retro-eligibility issue
☐ Other: _____

Mail this form, a listing of claims (if applicable) and supporting documentation to:

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