



Provider Payment Appeal and Correspondence Submission Form

Use this form for payment appeals and claim correspondence only.

Member first/last name: _____ Member DOB: _____
Amerigroup ID: _____
Medicaid/CHIP ID: _____
Provider first/last name: _____ Provider ID: _____
☐ Participating provider ☐ Nonparticipating provider
Provider contact first/last name: _____ Contact phone: _____
Provider street address: _____
City: _____ State: _____ ZIP: _____ Phone: _____
Claim number: _____ 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 appeal or claim correspondence section below.

Payment appeal (check the appropriate box): ☐ First-level appeal ☐ Second-level appeal

A payment appeal is defined as any claim payment disagreement between Amerigroup and the health care provider for reasons including but not limited to contractual payment issues, timely filing and notification/authorization issues.

Clearly and completely indicate the payment appeal reason(s). You may attach an additional sheet if necessary. **Please include any appropriate medical records.**

Claim correspondence (check the appropriate box below):

Claim correspondence is defined as additional requested information necessary in order for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

☐ Itemized bill/medical records (in response to a claim denial or request from Amerigroup)
☐ 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:

Provider Payment Appeals
Amerigroup

Virginia Beach, VA 23466-1599

Amerigroup Appeal Forms For Providers

David Kirk



Amerigroup Appeal Forms For Providers:

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