Amerigroup
An Anthem Company

https://providers.amerigroup.com

Claim Payment Appeal Submission Form

Member information

Member first/last name:		
Member ID:		
Member DOB:		

Provider/provider representative information

Provider first/last name:		
NPI number:		
Provider street address:		
City:	State:	ZIP code:
☐ I am a participating provider.	☐ I am not a participating provider.	
Provider representative: ☐ Self ☐ Billing agency ☐ Law firm ☐ Other: _____		
Representative contact name:		
Contact phone:		
Email:		
Street address:		
City:	State:	ZIP code:

Claim information*

Claim number:
Billed amount: $
Amount received: $
Start date of service:
End date of service:
Authorization number:

* For multiple claims related to the same issue, providers can use one form and attach a listing of the claims with each supporting document. **This form is a required attachment for all Claim Payment Appeals.**

Claim Payment Appeal

All Claim Payment Appeals must be submitted in writing or via our provider website. We accept web and written payment Claim Payment Appeals within 30 calendar days of the date the *Reconsideration Determination* letter was mailed. A Claim Payment Appeal is defined as a request from a health care provider to change a decision made by Amerigroup Washington, Inc., related to a claim payment for services already provided. A provider Claim 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*.

Claim Payment Reconsideration reference number:

_____

Reason for Claim Payment Appeal

To ensure timely and accurate processing of your request, please check the applicable determination provided on the *EOP*.

- ☐ Untimely filing
- ☐ No authorization
- ☐ Denied for other health insurance (OHI) but member does not have OHI
- ☐ Experimental/investigational procedure denial
- ☐ Claim code editing denial
- ☐ Retrospective authorization issue
- ☐ Disagree that you were paid according to contact
- ☐ Data elements on the claim on file do no match the claim originally submitted
- ☐ Denied as duplicate
- ☐ Denial related to provider date issue
- ☐ Member retro-eligibility issues
- ☐ ER level of payment review
- ☐ Other

Mail this form (or upload if filing a web Claim Payment Appeal), a listing of claims (if applicable) and supporting documentation to:

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