Coordination of Benefit
Explanation of Benefits Copayment Request Form

Use this form when:

- Amerigroup is the secondary carrier
- The primary carrier has capitated the provider for services rendered
- In addition to the capitation payment, a member copayment is due

Instructions:

- Complete the information below
- Complete and attach a CMS-1500 (08-05) form (or its successor form)
- Provide a photocopy of the primary carrier's member ID card, if available
- Forward all completed documents and claim form(s) to the Claims department at:

Claims
Amerigroup Community Care
P.O. Box 61010
Virginia Beach, VA 23466-1010

Member name: _____

Amerigroup ID: _____

State Medicaid ID: _____

Carrier paying capitation: _____

Primary carrier member ID number: _____

☐ There is no explanation of benefit available. The copayment for this service is $_____.

I certify that, to the best of my knowledge, the information above is verified and accurate, and that this notification form applies to any associated claim(s) and is made a part thereof.

_____ _____ _____

Signature of patient account representative | Date | Provider ID

This form may be photocopied.