Claim Correspondence – Submission Form

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

Member Information:

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

Member Coverage: ☐ Medicaid ☐ Medicare

Member ID: _____

Provider/Provider Representative Information:

Provider First/Last Name: _____

Provider Street Address: _____

City: _____ State: _____ ZIP Code: _____ Phone (_____)_____

National Provider Identification Number: _____

Select one: ☐ 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: _____

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.

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.

To ensure timely and accurate processing of your request, please complete the section below by checking the applicable category your correspondence applies to.

☐ Itemized bill
☐ Abortion consent form
☐ Corrected claim
☐ ER Level of Payment Review
☐ Sterilization consent form
☐ Invoice
☐ Other health insurance information
☐ Hysterectomy consent form
☐ Medical records
☐ Other: _____

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

Claim Correspondence
Amerigroup
P.O. Box 61599
Virginia Beach, VA 23466-1599