



<https://providers.amerigroup.com>

**Florida Statewide Medicaid Managed Care Long Term Care
roster billing**

Fax to: 1-866-779-3031

Amerigroup
Provider ID
number (PIN).

Enter the
date you are
completing
this form.

For example,
Page 1 of 1.

Insert the legal
name of the
facility.

Insert the facility's Federal
Tax ID Number (EIN or
TIN)

Provider Name: _____ TIN: _____ PIN #: _____ Date of Submission (MM-DD-YY): _____ Page ___ of ___

Member Name	AMERIGROUP ID#	Member DOB	Diagnosis Code	Date(s) of Service		Procedure Code	Modifier	Days or Units	Charges
				From (MM-DD-YY)	To (MM-DD-YY)				
			R69						

Enter all
DOS from
the first to
the first of
the same

Claims questions/issues:

English — Press option 1 OR Spanish —
Press option 2
Florida — Press option 1
Providers — Press option 3
Claims — Press option 1 OR Other
Inquiries — Press option 2

Additional Comments: _____

Claims Inquiries: 877-440-3738

Facility Signature: _____ Date Signed: _____ Phone Number: _____

DISCLAIMER

This is not a guarantee of payment. Reimbursement of your medical claim is subject to the terms of the specific coverage including, but not limited to, member eligibility, plan policy limitations or exclusions, plan benefits, timely claims filing and accurate billing of services. Benefits will be determined upon receipt of the claims. In order for claims to be processed accurately and in a timely manner, prior authorization for these services must be obtained. If you have any questions regarding authorized services, please contact your Amerigroup Care Coordinator.