Provider Administrative Review Request Form (medical necessity appeals only)

Thank you for contacting AMERIGROUP Community Care. Please note that all nonexpedited appeals must be submitted in writing to the AMERIGROUP Appeals Specialty Unit. This form will help ensure that your appeal is processed as efficiently and effectively as possible. Please fill out the form completely.

Check here if this is an Expedited Appeal Request. Please review the definition below.

- ❑ **Expedited Request –** Applies when the standard 30-calendar-day timeframe could jeopardize the member's ability to reach and maintain maximum function or the denial could significantly increase the risk to a member health or life. A decision will be made within 72 hours. Fax the request to 1-877-842-7183.

Member Information

Last name: ______________________ First name: ______________________

Member #: ______________________

Address: ______________________

City: ______________________ State: ____________ Zip____________

Provider Information

Last name: ______________________ First name: ______________________

Facility ______________________

TIN#: ______________________ Provider #: ______________________

Address: ______________________

City: ______________________ State: ____________ Zip: ____________

Claim Data (if applicable)

Claim #: ______________________ Authorization #: ______________________

Date service started: ______________________ Date service ended:______________________

Check reason for denial as indicated in notice of proposed action:

- ❑ Medical necessity
- ❑ Lower level of care
- ❑ Lack of information
- ❑ No prior authorization
- ❑ Late notification
- ❑ Benefit not covered/experimental
- ❑ Exceeds authorization
- ❑ Other:______________________

Check the items being submitted with the appeal:

- ❑ Evidence of eligibility verification
- ❑ Medical records
- ❑ Evidence of timely appeal submission
- ❑ Letter from member designating provider as authorized representative
- ❑ Approved authorization letter or correspondence from AMERIGROUP indicating approval

Note: Send this form with written member consent and all pertinent medical documentation to support the request to: AMERIGROUP Community Care ● Medical Appeals ● P.O. Box 62429 ● Virginia Beach, VA 23466-2429.

Signature: ______________________ Date: ______________________