Authorization Form

Submit this completed *Authorization Form* with all supporting documentation to ensure proper processing of your request to adjust claims as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

Provider name	
Provider NPI	
Provider tax identification number	
Provider contact information	
Cost Containment project number (if applicable)	
Document identification number (if applicable)	
Total recoupment dollar amount	

Please list claim information below if the *Cost Containment Letter* or other supporting claim/member detail is not provided with this request.

Claim number	**Member number**	**Service dates**	**Recoupment amount**
Recoupment reason			
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Recoupment reason			
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If your request for recoupment exceeds the space provided, please attach an excel file that includes all the data noted above. For questions related to the completion of this form, please call Provider Services at 1-800-454-3730.

I authorize Amerigroup to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

_____ _____

Print name Signature

Mail this form to:
Attn: Cost Containment – Disputes
Amerigroup
P. O. Box 62427
Virginia Beach, VA 23466-2437

Note: Do not use this form if you are submitting a refund check. If you would like to submit a refund, please use the *Refund Notification Form* on the provider website. Mail a check along with the supporting documentation to:

Attn: Cost Containment – Payments
Amerigroup
P.O. Box 933657
Atlanta, GA 31193-3657