Claim Payment Appeal Submission form

Member information

Member first/last name: _____ Member date of birth: _____
Member ID: _____

Provider/provider representative information

Provider first/last name: _____ NPI number: _____
Provider street address: _____
City: _____ State: _____ ZIP code: _____
☐ 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: _____ Email: _____
City: _____ State: _____ ZIP code: _____

Claim information*

Claim number: _____ Billed amount: $_____ Amount received: $_____
Start date of service: _____ End date of service: _____ Authorization number: _____

***** For multiple claims related to the same issue, providers can use one form and attach a listing of the claims with each supporting document. **This form is a required attachment for all appeals.**

Payment appeal

All appeals must be submitted in writing or via our provider website. We accept web and written payment appeals within 60 calendar days (63 days if mailed) of the date on the *Reconsideration Determination* letter (if one was filed) or within 60 calendar days (63 days if mailed) of the date on your *Explanation of Payment*. A payment appeal is defined as a request from a health care provider to change a decision made by Amerigroup Kansas, Inc. related to a claim payment for services already provided. A provider payment appeal is not a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a *Notice of Action*.

Providers will receive a *Payment Appeal Determination* letter. If providers disagree with the payment appeal determination, they have an additional 30 calendar days (33 days if mailed) from the date of the determination letter to file a *Request for State Fair Hearing.*

Payment reconsideration reference number (if applicable): _____

Payment dispute

To ensure timely and accurate processing of your request, please check the applicable determination provided on the Amerigroup *Determination Letter* or *Explanation of Payment*.

☐ Untimely filing
☐ No authorization
☐ Denied for other health insurance (OHI), but member doesn't have OHI
☐ Experimental/investigational procedure denial
☐ Claim code editing denial
☐ Retrospective authorization issue
☐ Disagree that you were paid according to your contract
☐ Data elements on the claim on file does not match the claim originally submitted
☐ Denied as duplicate
☐ Denial related to provider data issue
☐ Member retro-eligibility issue
☐ ER level of payment review
☐ Other: _____

Mail this form (or upload if filing a web appeal), a listing of claims (if applicable) and supporting documentation to:

Payment Appeals, Amerigroup Kansas, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

https://providers.amerigroup.com/KS