Provider Medical Necessity Appeals - Submission Form

This form should be completed by Providers for Medical Necessity Appeals only.

Member First/Last Name_____ Member Date of Birth_____

Member Amerigroup, Medicaid # (circle one) _____

Provider First/Last Name_____ National Provider Identification (NPI) _____
□Participating □Non-Participating

Provider Contact First/Last Name_____ Contact Phone (____) _____ _____

Provider Street Address_____

City_____ State_____ Zip_____ Phone (_____) _____

Claim #_____ Billed Amount $_____ Amount Received $_____

Start Date of Service _____ End Date of Service _____ Auth #_____

To ensure timely and accurate processing of your request, please document your request and include all supporting medical records.

Medical Appeal: Check (✓) One → □**First-Level Appeal** □ **Second-Level Appeal**

An appeal is defined as "**a request for a review of an action**." An action is defined as "**the denial or limited authorization of a request, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of a payment for a service; or the failure of the health plan to act within established time requirements (provided in 42 CFR 438.408 (b)) for service accessibility.** "All appeals with member liability must follow the applicable appeals process. Please refer to the Explanation of Payment (EOP) to ensure you are following the correct process.

Clearly and completely indicate the appeal reason(s). You may attach an additional sheet if necessary. **Please include appropriate medical records**.

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_____
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_____

Mail this form and supporting documentation to:

Amerigroup Kansas, Inc.
Medical Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429