# Provider Coversheet (MD)

Thank you for participating in the Amerigroup Community Care network!

Please review the below options and check the information you are submitting with your claim. Please attach this coversheet with your claim before submitting. (*The information submitted is necessary for a claim to be considered a clean claim and for a correct reimbursement determination to be made*.)

For payment disputes, appeals, grievances and refunds, please use the appropriate submission form located on our web site at www.amerigroupcorp.com/providers. To download forms, go to Downloadable Forms under Office Support.

Member Name: ______________________________
Member ID Number: ______________________________
(Please complete a coversheet for each member)

Provider Contact: ____________________ Contact Phone: ____________________
Provider Street Address: ____________________ City: __________ State: _____ ZIP: __________

**Medical Records:**
☐ Emergency Room (ER) initial submission

**Itemized Bill:**
☐ Other:
Description: ______________________________

☐ **Corrected claim – Corrected billing of a previously processed claim**
☐ Corrected diagnosis
☐ Corrected date of service
☐ Corrected charges
☐ Corrected patient information
☐ Corrected procedure code (CPT or ICD-9-CM)
☐ Addition or correction of modifier
☐ Corrected provider information
☐ Other: ______________________________

☐ **Sterilization and/or Hysterectomy Forms**

☐ **Invoice**

☐ **Other**
Description: ______________________________

Please submit above documents and this form to:

Claims Correspondence
Amerigroup Community Care
P.O. Box 61599
Virginia Beach, VA 23466