providers.amerigroup.com

Provider Request for Appeal Form

To request an appeal, please complete this form and mail it back to us. We will send you a letter within five days to let you know we received your request. Within 30 days of receiving either this form or your oral appeal (with this form filed timely thereafter), we will send you a letter to let you know our decision.

I am requesting a(n) ☐ **Standard appeal** ☐ **Expedited appeal**

Member name: _____

Parent or guardian name (if service is for a child): _____

Amerigroup ID number: _____

Reference number: _____

Physician name: _____

Physician office address: _____

_____

Physician office phone number(s): _____ / _____

Type of service you want to provide or provided: _____

Reason the member needs or received this service: _____

Date you provided or plan to provide this service: _____

Reason you are asking for an administrative review: _____

_____

Sign and send this form to:

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

Signature: _____ **Date:** _____

For assistance, please call Provider Services at 1-800-454-3730 (TTY 1-800-855-2880) Monday through Friday from 7:00 a.m. to 7:00 p.m. local time.

Please note: You must have the member's consent to file an appeal.

*In Louisiana, Amerigroup Louisiana, Inc. In New Mexico, Amerigroup Community Care of New Mexico, Inc.