Provider Payment Dispute and Correspondence – Submission Form

This form should be completed by Tennessee Providers for Payment Disputes and Claim Correspondence only.

Member First/Last Name_____ Member DOB _____

Amerigroup, Medicaid or Medicare (circle one) Member #_____

Provider First/Last Name_____ Provider #_____

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

☐ Participating
☐ Non-Participating: If filing for a Medicare member and the member has potential financial liability, you must include a completed CMS Waiver of Liability form.

Provider Street Address_____

City_____ State_____ ZIP_____ Phone (_____) _____

Claim #_____ Billed Amount $_____ Amount Received $ _____

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

In accordance with Tennessee statute T.C.A. 56-32-126, providers have an external independent review process available if you continue to disagree with a payment decision after receiving a decision from a health plan's internal dispute process. For specific instructions and requirements for this process, please review the Tennessee regulation. A form for filing is located at http://www.tn.gov/tncoversight/PCIR.shtml. Please be aware there is a fee associated with each claim requested for review that must be paid by the provider if the external reviewer upholds our determination. Please note this process is not applicable to Medicare member's liability denials.

PAYMENT DISPUTE

A payment dispute is defined as a dispute between the provider and Amerigroup in reference to a claim determination where the member cannot be held financially liable. All disputes with member liability must follow the applicable appeals process. Please refer to the explanation of payment to ensure you are following the correct process.

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

_____

_____

CLAIM CORRESPONDENCE: Check (√) appropriate box below.

Claim correspondence is defined as a request for additional/needed information in order for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

☐ **Itemized Bill/Medical Records** (In response to an Amerigroup claim denial or request)

☐ **Corrected Claim** ☐ **Other Insurance/Third-Party Liability Information** ☐ **Other Correspondence**

Clearly and completely indicate the reason(s) for your correspondence. You may attach an additional sheet if necessary.

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_____

Mail this form and supporting documentation to:

Payment Disputes
Amerigroup Community Care
P.O. Box 61599
Virginia Beach, VA 23466-1599

Amerigroup RealSolutions in healthcare

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Member First/Last Name 1 _____ Member DOB 2 _____

AMERIGROUP, Medicaid or Medicare (circle one) Member # 3 _____

Provider First/Last Name 4 _____ Provider # 5 _____

Provider Contact First/Last Name 6 _____ Contact Phone (___) 7 _____

8 ☐ Participating

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Provider Street Address 9a _____

City 9b _____ State 9c Zip 9d Phone (_____) 9e _____

Claim # 10 _____ Billed Amount $ 11 _____ Amount Received $ 12 _____

Start Date of Service 13 _____ End Date of Service 14 _____ Auth # 15 _____

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Payment Disputes
PO Box 61599
Virginia Beach, VA 23466-1599