Amerigroup
An Anthem Company

https://providers.amerigroup.com

Provider Payment Dispute and Claim Correspondence Submission Form

Use this form for payment disputes and claim correspondence only.

Member first/last name:		
Member DOB:		
Amerigroup ID:	Medicaid/CHIP ID:	
Provider first/last name:		
Provider ID:		
☐ Participating provider	☐ Nonparticipating provider	
Provider contact first/last name:		
Provider contact phone:		
Provider street address:		
City:	State:	ZIP:
Phone:		
Claim number:		
Billed amount: $	Amount received: $	
Start date of service:	End date of service:	
Authorization number:		

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

To ensure timely and accurate processing of your request, please complete the payment dispute or claim correspondence section below.

Payment dispute

The simplest way to define a payment dispute is when a claim is finalized, but you disagree with the outcome.

The payment dispute process consists of two options: reconsideration and claim payment appeal. For the first time disputing the payment, choose **reconsideration** so that you can have two levels of appeal, if needed. If a reconsideration has been completed, choose **claim payment appeal**. If unsure, choose **reconsideration**.

Payment dispute (check the appropriate box): ☐ Reconsideration ☐ Claim payment appeal

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

Claim correspondence (check the appropriate box below):

Claim correspondence is defined as additional requested information necessary 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 claim denial or request from Amerigroup)

☐ 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.

Mail this form and supporting documentation to:

Payment Dispute Unit
Amerigroup
P.O. Box 61599
Virginia Beach, VA 23466-1599