

Claim Payment Appeal Submission Form

Member information

Member first/last name:		
Member ID:		
Member DOB:		

Provider/provider representative information

Provider first/last name:		
NPI number:		
Provider street address:		
City:	State:	ZIP code:
<input type="checkbox"/> I am a participating provider. <input type="checkbox"/> I am not a participating provider.		
Provider representative: <input type="checkbox"/> Self <input type="checkbox"/> Billing agency <input type="checkbox"/> Law firm <input type="checkbox"/> Other: _____		
Representative contact name:		
Contact phone:		
Email:		
Street address:		
City:	State:	ZIP code:

Claim information*

Claim number:
Billed amount: \$
Amount received: \$
Start date of service:
End date of service:
Authorization number:

* For multiple claims related to the same issue, providers can use one form and attach a listing of the claims with each supporting document. **This form is a required attachment for all Claim Payment Appeals.**

Claim Payment Appeal

All Claim Payment Appeals must be submitted in writing or via our provider website. We accept web and written payment Claim Payment Appeals within 60 calendar days of the date the *Reconsideration Determination* letter was mailed. A Claim Payment Appeal is defined as a request from a health care provider to change a decision made by Amerigroup Washington, Inc., related to a claim payment for services already provided. A provider Claim Payment Appeal is **not** a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a *Notice of Action*.

Claim Payment Reconsideration reference number:

Reason for Claim Payment Appeal

To ensure timely and accurate processing of your request, please check the applicable determination provided on the *EOP*.

- | | | |
|---|--|--|
| <input type="checkbox"/> Untimely filing | <input type="checkbox"/> Claim code editing denial | <input type="checkbox"/> Denied as duplicate |
| <input type="checkbox"/> No authorization | <input type="checkbox"/> Retrospective authorization issue | <input type="checkbox"/> Denial related to provider date issue |
| <input type="checkbox"/> Denied for other health insurance (OHI) but member does not have OHI | <input type="checkbox"/> Disagree that you were paid according to contact | <input type="checkbox"/> Member retro-eligibility issues |
| <input type="checkbox"/> Experimental/investigational procedure denial | <input type="checkbox"/> Data elements on the claim on file do no match the claim originally submitted | <input type="checkbox"/> ER level of payment review |
| | | <input type="checkbox"/> Other |

Mail this form (or upload if filing a web Claim Payment Appeal), a listing of claims (if applicable) and supporting documentation to:

Claim Payment Appeals
Amerigroup Washington, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599