



# Claim Payment Appeal – Submission Form

This form should be completed by providers for payment appeals only.

### Member Information:

Member First/Last Name: _____	Member Date of Birth: _____
Member Coverage: <input type="checkbox"/> Medicaid	Member ID: _____

### 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 a nonparticipating 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: (_____) _____
Representative Street Address: _____	Email: _____
City: _____	State: _____ ZIP Code: _____

### Claim Information\*\*:

Claim Number: _____	Billed Amount: \$ _____	Amount Received: \$ _____
Start Date of Service: _____	End Date of Service: _____	Authorization Number: _____

\*\* If you have multiple claims related to the same issue, you can use one form and attach a listing of the claims with each supporting document following behind.

### Payment Appeal

A payment appeal is defined as a request from a health care provider to change a decision made by Amerigroup related to claim payment for services already provided. A provider 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.

- First-level Appeal       Second-level Appeal (Not available in Ohio)

To ensure timely and accurate processing of your request, please complete the Payment Dispute section below by checking the applicable determination provided on the Amerigroup determination letter or Explanation of Payment.

- |   |   |  |
|---|---|--|
| <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 data issue |
| <input type="checkbox"/> Denied for Other Health Insurance (OHI), but member doesn't have OHI | <input type="checkbox"/> Disagree that you were paid according to your contract                           | <input type="checkbox"/> Member retro-eligibility issue        |
| <input type="checkbox"/> Experimental/investigational procedure denial                        | <input type="checkbox"/> Data elements on the claim on file does not match the claim originally submitted | <input type="checkbox"/> Other: _____                          |

Mail this form, a listing of claims (if applicable) and supporting documentation to:

**Payment Appeals**  
**Amerigroup**  
**P.O. Box 61599**  
**Virginia Beach, VA 23466-1599**