AmeriHealth Caritas VIP Care

# Provider Claim Dispute Form

A dispute is a request from a health care provider to change a decision made by AmeriHealth Caritas VIP Care related to claim payment or denial for services already provided. A provider dispute is not a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

A provider may dispute the claim within **180 days** from the date of the denial or payment.

| **Submitter contact information** | |
|---|---|
| Name (last, first):_____ | Phone number:_____ |

| **Provider information** | |
|---|---|
| Name (last, first):_____ | Phone number:_____ |
| NPI number: _____ | Tax ID:_____ |
| ❑ I am an in-network provider | ❑ I am an out-of-network provider |

| **Member information** | |
|---|---|
| Name (last, first):_____ | Member date of birth:_____ |
| Member ID:_____ | |

| **Claim information** | |
|---|---|
| Claim number:_____ | Billed amount: $_____ |
| Dates of services: _____ | |

Continued on other side.

## Provider Claim Dispute Form

To ensure timely and accurate processing of your request, please complete the payment dispute section below by checking the applicable reason for your dispute.

❏ Inaccurate payment

❏ Post-service authorization denial

❏ Denied as a duplicate

❏ Clinical edit limitation or denial

❏ Denied for no primary payer Explanation of Benefits (EOB, attached)

❏ Denied for no authorization (service does not require authorization)

❏ Denied for no authorization (auth. #_____ on file)

❏ Untimely filing (proof of timely filing attached)

❏ Other:_____

| Signature: | Date: |
|---|---|

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

**AmeriHealth Caritas VIP Care**
**Attn: Claim Disputes**
**P.O. Box 7155**
**London, KY 40742-7155**

**Important note:** A telephone inquiry regarding payment or denial of a claim does not constitute dispute of the claim.

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