AmeriHealth Caritas District of Columbia

Provider Claim Dispute Form

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

AmeriHealth Caritas District of Columbia
Attn: Claim Disputes P.O. Box 7358
London, KY 40742

A dispute is defined as a request from a health care provider to change a decision made by AmeriHealth Caritas District of Columbia 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.

☐ First Level Dispute ☐ Second Level Dispute

Submitter/Contact Information:	
Name (Last, First):	Phone Number:

Provider Information:	
Name (Last, First):	Phone Number:
Provider Address:	City, State, ZIP:
NPI Number:	Tax ID:
Date:	
☐ I am a participating provider	☐ I am not a participating provider

Enrollee Information:	
Name (Last, First):	Enrollee Date of Birth:
Enrollee ID:	

Claim Information:	
Claim Number:	Billed Amount: $
Date(s) of Services:	

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 EOB (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: _____

Additional Information:

DHCF This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.

GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR