Provider Appeal Submission Form

AmeriHealth Caritas District of Columbia

Providers may file an appeal on claim denial for medical necessity within 60 days of the notice of Adverse Benefit or Claim Payment Denial.

Does this service relate to a post-service denial for medical necessity?

☐ **Yes**
A provider appeal may be submitted using this form. Mail it and supporting documentation to:

AmeriHealth Caritas District of Columbia
Provider Claim Appeals (Medical Necessity)
P.O. Box 7359
London, KY 40742
Fax: 1-877-759-6223

☐ **No**
Please do not use this form. Complete the Provider Dispute Submission From found here:

https://www.amerihealthcaritasdc.com/content/dam/amerihealth-caritas/acdc/pdf/provider/provider-claim-dispute-form.pdf.coredownload.inline.pdf

I am requesting:

☐ **Standard provider appeal (30 days):** Please note this claim appeal review is just a review for medical necessity.

Submission date:

Section I: Provider/Facility Information	
Health care provider/facility name:	
Requesting provider signature:	
Submitter name (if different from above):	
Phone:	Fax:
Tax ID:	NPI:
Provider mailing address:	
Referring health care professional name (if applicable):	
Section II: Member Information (if applicable)	
Member name:	
Member date of birth:	
Member ID (copy from member ID card):	
Section III: Claim Information (for a provider looking to appeal a claim denial that is for a medical necessity)	
Claim number:	Billed amount: $
Date of service:	

☐ **Supporting documentation attached**

State your rationale for the appeal and the expected outcome **(please attach any supporting documentation)**:

If you have any questions, please call your Account Executive or Provider Services at **1-888-656-2383**.