AmeriHealth Caritas Ohio

Provider Dispute Submission Form

Provider claim disputes are any provider inquiries or requests for reconsiderations, ranging from general questions about a claim to a provider disagreeing with a claim denial. A dispute can be submitted using any of the methods below:

Phone: 1-833-644-6001 (Select the prompts for the correct department and then select the prompt for claim issues.)

NaviNet: Use the claims adjustment inquiry function.

Mail:
AmeriHealth Caritas Ohio
Attn: Provider Claim Inquiry
P.O. Box 7126
London, KY 40742

Fax: 1-833-216-2272

Submission date: _____

Section I: Request
☐ Dispute
☐ Dispute with medical necessity review
☐ External medical review

Section II: Provider/Practitioner/Facility information	
Healthcare provider/practitioner/facility name:	
Requesting physician signature:	
Submitter name (if different than above):	
Phone:	Fax:
Tax ID:	
NPI:	
Physician mailing address:	
Referring healthcare professional name (if applicable):	

Section III: Member information (if applicable)
Member name:
Patient date of birth:
Member ID (copy from member's ID card)

Section IV: Claim information (if applicable)				
Claim identification number:				
Date of notification/payment from AmeriHealth Caritas Ohio:		Date of service From:		To:

CPT codes							
Diagnosis codes							

Section V: Provider dispute submission (Please indicate the type of dispute.)

☐ Eligibility	☐ Provider not credentialed
☐ TPL/Other insurance	☐ Duplicate claim
☐ Improper claim submission	☐ Timely filing
☐ Overpayment	☐ Documentation issues
☐ Self-identified	☐ Recoupments
☐ Plan-identified	☐ Prior authorizations
☐ Program Integrity-identified	☐ Medical necessity
☐ Vendor-identified	☐ Provider affiliations
☐ Underpayment	☐ Payment amount clarification
☐ Contract/Fee schedule	☐ Patient liability
☐ Negotiated rate	☐ Level of care (LOC)
☐ Related edit	☐ Claim status
☐ Other provider reason:	☐ Sterilization/hysterectomy consent
☐ Provider not eligible to provide service	☐ Past dispute time frame
☐ Non-covered service	
☐ Payment not received	

☐ 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 Provider Services Account Executive or Provider Services at **1-833-644-6001**.