

# Hospital Appeal/ Provider Complaint Form

A Hospital Appeal is a request for AmeriHealth Caritas Delaware to review a decision about a member's care or adjustment of a payment in accordance with the terms specified in the Hospital agreement; AmeriHealth Caritas Delaware Provider Manual; and/or written policies and procedures.

A **Provider Complaint** is a request from a health care provider to change a decision made by AmeriHealth Caritas Delaware related to claim payment, policy procedure or administrative functions, or denial for services already provided. A provider complaint is not a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

A provider may file a written complaint no later than 12 months from the date of service or 60 calendar days after the payment, denial, or recoupment of a timely claims submission, whichever is latest.

Submitter contact information	Submission date:
Name (last, first):	Phone:
Title/position:	Email:

Hospital information /provider/practicete:			
Hospital/provider/practice name:			
Rendering provider name (last, first):			
Phone:	NPI number:		Tax lD:
□ Participating provider		□ Not a participatin	g provider

Member information	
Name (last, first):	
Member date of birth:	Member ID:

Client information	
Claim number:	Remittance advice/processing date:
If your expectation is a claim payment, please provide the claim number.	
Billed amount: \$	

Type of appeal/complaint:  □ Clinical   □ Administrative
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# **Claim-related issue**

To ensure timely and accurate processing of your request, please complete the payment inquiry section below by checking the applicable reason for your inquiry.	
Reason for your complaint or appeal:	
□ Inaccurate payment	$\Box$ Denied for no authorization (service does not require authorization)
□ Claim processing error	□ Denied for no authorization (authorization # on file)
$\Box$ Post-service authorization denial	$\Box$ Untimely filing (proof of timely filing attached)
□ Denied as a duplicate	□ Other complaint for issue not about claims
□ Clinical edit limitation or denial	
□ Denied for no primary payer Explanation of Benefits (EOB attached)	
$\Box$ Payment takeback or recoupment	
Supporting documentation included: $\Box$ Yes $\Box$ No	
	Primary payer EOB
	$\Box$ Proof of timely filing
□ Medical records	□ Other:

### Non-claim-related issues — Please provide a brief summary of the issue(s)

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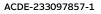
Signature:	Date:

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

AmeriHealth Caritas Delaware Attn: Provider Complaints P.O. Box 80101 London, KY 40742-0101

#### Fax number: 1-855-347-0023

**Important note:** A provider may file a written complaint no later than 12 months from the date of service or 60 calendar days after the payment, denial, or recoupment of a timely claims submission, whichever is latest.



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