

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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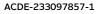
Signature:	Date:

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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