AmeriHealth

EMERGENCY ROOM REVIEW FORM

Please complete the following information and attach this form with each Emergency Room Medical Record. Thank You!

******Product (Please Circle One)******

AmeriHealth Commercial HMO

AmeriHealth 65

AmeriHealth 65 Choice

AmeriHealth Point-of-Service

AmeriHealth PPO

PROVIDER NAME_____

NPI and/or 10-DIGIT LEGACY PROVIDER ID NUMBER_____

PATIENT ID NUMBER_____

DATE OF SERVICE _____

AMERIHEALTH CLAIM NUMBER_____

PATIENT'S FIRST NAME_____

PATIENT'S LAST NAME _____

_____ ( ) _____

Form Completed By *(Please Print)* Telephone Number

******Return Completed Form with Medical Records to:******

Claims Medical Review - Emergency Room Review
AmeriHealth
1901 Market Street
Philadelphia, PA 19103-148