



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 Point-of-Service

AmeriHealth 65[®]

AmeriHealth PPO

AmeriHealth 65 Choice

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 19103-1480