



Reference # \_\_\_\_\_  
 Date submitted   /   /    
 Pages attached

## PROVIDER CLAIM INQUIRY FORM

Inquiry type:  Amount of payment questioned     Denied claim questioned

To ensure that your request is handled promptly and accurately, please mail the completed form and supporting documentation to the address listed in the box below. If you do not include the claim number, then you *must* include the Statement of Remittance (SOR).

**AmeriHealth Provider Claim Inquiries**  
**P.O. Box 7930**  
**Philadelphia, PA 19101-7930**

**Note: If your office is registered with NaviNet<sup>®</sup>, please submit claim inquiries electronically.**

Member's plan:  AmeriHealth PPO     AmeriHealth HMO     AmeriHealth 65<sup>®</sup> NJ HMO  
 AmeriHealth Point-of-Service     Other \_\_\_\_\_

Practice name			Provider number/NPI
Street address			Name of contact person
City	State	ZIP	Telephone number

Member name	Patient's name
Member ID	Check number
<b>Claim number</b>	Date of check or explanation
Date of service	Place of service

*Detailed inquiry reason*

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*AmeriHealth maintains processes to address and resolve provider inquiries and provider complaints related to the adjustment of claims. If you would like us to investigate the way we have processed a particular claim, please complete this form and send it to us, along with the SOR (or claim number) and any supporting documentation to the address above.*

*We will investigate your claims-related issue, process any required adjustments, or send you a written resolution letter regarding the processing of the claim.*

**If you have any questions, please contact Customer Service at 1-800-275-2583.**

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