AmeriHealth

Reference #: _____
Date Submitted: ☐☐/☐☐/☐☐
Pages Attached: ☐☐☐☐

PHYSICIAN CLAIM INQUIRY FORM

Check here for inquiry type: ☐Amount of Payment Questioned ☐Rejection Questioned

Please follow these instructions carefully to ensure that your request is handled promptly and accurately.
Please mail completed form, Statement of Remittance, and supporting documentation to:

AmeriHealth Claims Inquiry
P.O. Box 6645
Wayne, PA 19087-6645

Member's Plan: ☐PPO ☐HMO ☐65 HMO ☐Point-of-Service ☐Other: _____

Practice Name			Provider Number
Street Address			Name of Contact Person
City	State	Zip	Telephone Number ( )

Member Name	Patient's Name
Member ID	Check Number
Claim Number	Date of Check or Explanation
Date of Service	Place of Service

Detailed Inquiry Reason:

_____

_____

_____

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If you have any questions, please contact Provider Services. Thank You.
HMO: 1-800-821-9412 PPO: 1-800-595-3627 Hours M-F 8AM - 5:30PM

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 AmeriHealth has processed a particular claim, please complete this form and send it to us, along with the statement of remittance and any supporting documentation to the address listed above.

We will investigate your claims-related issue, process any required adjustments, or send you a written resolution letter detailing the processing of the claim. If you are dissatisfied with the results of our investigation you may file a provider appeal. Instructions for filing an appeal will be provided in the resolution letter. You may also access our appeals process by following the instructions posted on AmeriHealth's website, ***www.amerihealth.com/providers.***

RETURN WITH REMITTANCE