AmeriHealth Caritas Delaware

Hospital Appeal/ Provider Complaint Form

☐ **Hospital Appeal** ☐ **Provider Complaint**

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/practice		
Hospital/provider/practice name:		
Rendering provider name (last, first):		
Phone:	NPI number:	Tax ID:
☐ Participating provider	☐ Not a participating provider	

Member information	
Name (last, first):	
Member date of birth:	Member ID:

Claim information	
Claim number: *If your expectation is a claim payment, please provide the claim number.*	Remittance advice/processing date:
Billed amount: $	

Type of appeal/complaint:	☐ Clinical	☐ Administrative

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
- ☐ Claim processing error
- ☐ Post-service authorization denial
- ☐ Denied as a duplicate
- ☐ Clinical edit limitation or denial
- ☐ Denied for no primary payer Explanation of Benefits (EOB attached)
- ☐ Payment takeback or recoupment
- ☐ Denied for no authorization (service does not require authorization)
- ☐ Denied for no authorization (authorization #_____ on file)
- ☐ Untimely filing (proof of timely filing attached)
- ☐ Other complaint for issue not about claims

Supporting documentation included: ☐ **Yes** ☐ **No**

- ☐ Authorization
- ☐ Invoice
- ☐ Medical records
- ☐ Primary payer EOB
- ☐ Proof of timely filing
- ☐ Other:

Claim-related issues — Please provide a brief summary of the complaint/appeal

Non-claim-related issues — Please provide a brief summary of the issue(s)

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.