

Provider Claim Dispute Form

A **dispute** is defined as a request from a health care provider to change a decision made by AmeriHealth Caritas Next related to claim payment or denial for services already provided. A provider dispute is not a pre-service appeal of a denied or reduced authorization for services. Providers must exhaust AmeriHealth Caritas Next's claim dispute process as a prerequisite to arbitration or litigation.



A product of AmeriHealth Caritas Indiana, Inc.

Submitter/Contact information		
Name (Last, First)	Submission date	Phone

Provider information		
Provider name (Last, First)	NPI #	Tax ID #
Phone	<input type="checkbox"/> I am a participating provider. <input type="checkbox"/> I am not a participating provider.	

Enrollee information		
Enrollee name (Last, First)	Date of birth	Enrollee ID#

Claim information		
Claim number	Billed amount	Date(s) of service(s)
Claim number	Billed amount	Date(s) of service(s)
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Claim number	Billed amount	Date(s) of service(s)

Attach additional sheets if necessary.

Payment dispute section	
To ensure timely and accurate processing of your request, please check the applicable reason below for your dispute.	
<input type="checkbox"/> Inaccurate payment	<input type="checkbox"/> Denied for no primary payer EOB (EOB attached)
<input type="checkbox"/> Post-service authorization denial	<input type="checkbox"/> Denied for no authorization (Service does not require authorization.)
<input type="checkbox"/> Denied as a duplicate	<input type="checkbox"/> Denied for no authorization (auth. # _____ on file)
<input type="checkbox"/> Clinical edit limitation or denial	<input type="checkbox"/> Untimely filing (proof of timely filing attached)
<input type="checkbox"/> Other:	
Additional information:	

Please mail this completed form and any supporting documentation to:

AmeriHealth Caritas Next
Provider Claims Disputes
P.O. Box 7451
London, KY 40742-7451