Provider Appeal Submission Form

AmeriHealth Caritas Next

A product of AmeriHealth Caritas North Carolina, Inc.

A provider appeal may be registered by completing this form and mailing it with any supporting documentation to the address below:

AmeriHealth Caritas Next
Provider Appeals
P.O. Box 7414, London, KY 40742-7414

Submission date:

Section I: Provider/facility information

Health care provider/facility name:	
Requesting provider signature:	
Submitter name (if different from above):	
Phone:	Fax:
Tax ID:	NPI:
Provider mailing address:	
Referring health care professional name (if applicable):	

Section II: Member information (if applicable)

Member name:
Member date of birth:
Member ID (copy from member ID card):

Section III: Claim information (if applicable)

Claim identification number:							
Date of notification/payment from plan:							
Date of service To:				From:			
CPT codes:							
Diagnosis codes:							

A provider has the right to appeal adverse actions taken by AmeriHealth Caritas Next. Appeals are available to a provider including the following reasons. **Please indicate the type of appeal.**

- ☐ **Program integrity-related findings or activities:**
  - ☐ Finding of fraud, waste, or abuse by the plan
  - ☐ Finding of or recovery of an overpayment by the plan
  - ☐ Withholding or suspension of a payment related to fraud, waste, or abuse concerns
- ☐ **Denial of a claim:**
  - ☐ Provide denial reason

☐ **Credentialing-related reasons:**

- ☐ A determination not to renew an existing contract based solely on objective quality reasons outlined in AmeriHealth Caritas Next Objective Quality Standards
- ☐ A determination not to initially credential and contract with a provider based on objective quality reasons

☐ **Agreement-related reasons**

- ☐ Violation of the agreement between AmeriHealth Caritas Next and the provider
- ☐ Termination of a Provider Agreement before the agreement period has ended for reasons other than when AmeriHealth Caritas Next's Fraud Control Unit, Centers for Medicare and Medicaid (CMS), North Carolina Department of Insurance, or a government agency has required the plan to terminate the agreement

☐ **Other reason**

☐ Supporting documentation attached

State your rationale for the appeal and the expected outcome. **(Please attach any supporting documentation.)**

If you have any questions, please call your Account Executive or Provider Services at **1-855-266-0219.**