AmeriHealth Caritas Delaware

# Hospital Appeal/ Provider Complaint Form

**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): | |
| Title/position: | |
| Phone: | Email: |

| **Hospital information /provider/practicete:** | | |
|---|---|---|
| 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: |

| **Client information** | |
|---|---|
| Claim number:<br>*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:

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

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| 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.