Provider Appeal Submission Form

AmeriHealth Caritas Ohio

Providers may file an appeal on a denied pre-service within 30 days of the notice of Adverse Benefit Determination (ABD).

Does this service relate to a pre-service denial for medical necessity?

☐ **Yes**
A provider appeal may be submitted using this form. Mail it and supporting documentation to:

AmeriHealth Caritas Ohio
Provider Appeals
P.O. Box 7400
London, KY 40742
Fax: 1-833-564-1329

☐ **No**
Please do not use this form. Complete the Provider Dispute Submission Form found here: **https://www.amerihealthcaritasoh.com/assets/pdf/provider/resources/forms/provider-dispute-submission-form.pdf**

I am requesting:

☐ **Standard provider appeal (10 days)**: This includes requests regarding policy research queries, coding, and rate change inquiries.

☐ **Expedited provider appeal (48 hours)**: This includes inquiries regarding member access to services, including urgent care.

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):

☐ 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 **1-833-644-6001.**