Anthem Blue Cross and Blue Shield Healthcare Solutions
Medicaid Managed Care

Claim Payment Appeal Submission Form

This form should be completed by providers for payment appeals only.

Member information:

Member first/last name: _____

Member DOB: _____ Member coverage: ☐ Medicaid

Member ID: _____

Provider/provider representative information:

Provider first/last name: _____

NPI: _____

Provider street address: _____

City: _____ State: _____

ZIP code: _____

☐ I am a participating provider. ☐ I am a nonparticipating provider.

Provider representative: ☐ Self ☐ Billing agency ☐ Law firm

☐ Other: _____

Representative contact name: _____

Contact phone number: _____

Email: _____

Representative street address: _____

City: _____ State: _____

ZIP code: _____

Claim information:*

Claim number: _____

Amount billed: $_____ Amount received: $_____

Start date of service: _____ End date of service: _____

Authorization number: _____

* If you have multiple claims related to the same issue, you can use one form and attach a listing of the claims with each supporting document.

https://mediproviders.anthem.com/nv

ANVPEC-0844-18 December 2018

Payment appeal
A payment appeal is defined as a request from a health care provider to change a decision made by Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) related to claim payment for services already provided. A provider payment appeal is **not** a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a notice of action.

☐ First-level appeal ☐ Second-level appeal

To ensure timely and accurate processing of your request, please complete the payment dispute section below by checking the applicable determination provided on the Anthem determination letter or explanation of payment.

☐ Untimely filing	☐ Claim code editing denial	☐ Denied as duplicate
☐ No authorization	☐ Retrospective authorization issue	☐ Denial related to provider data issue
☐ Denied for other health insurance (OHI), but member doesn't have OHI	☐ Disagree that you were paid according to your contract	☐ Member retro-eligibility issue
		☐ ER level of payment review
☐ Experimental/investigational procedure denial	☐ Data elements on the claim on file do not match the claim originally submitted	☐ Other: _____ _____

Mail this form, a listing of claims (if applicable) and supporting documentation to:
Anthem Blue Cross and Blue Shield Healthcare Solutions
Payment Appeals/Disputes
P.O. Box 61599
Virginia Beach, VA 23466-1599