www.myamerigroup.com

MEDICAL APPEAL FORM

Please fill out this form. You do not have to send the form to us but it will help Amerigroup look at your appeal. Please fill out the whole form. You can also call us to ask for an appeal or if you need help with this form. Call Member Services at 1-800-600-4441. We will process your appeal request made by telephone even if you do not send this form.

We will send you a letter within 30 days of when we get your appeal request. The letter will let you know what we decide.

RE: Member Name: ______________________________________

Member ID Number: ___________________________________

CHIP ID Number: ______________________________________

Parent or Guardian's Name

(If the service is for your child): ___________________________

Reference or Authorization Number from denial letter: _________________

Type of services you want or received: ____

Why you want or receive the service: ____

Date you had or want to receive the service: _______________

Why are you appealing: ____

____

You can send us this form and any other information you feel we need to look at for your appeal to the address below.

I authorize _______________________________to appeal on my/my child's behalf.

Send this form to:

Health Care Management Services/Appeals
Amerigroup
2505 N Hwy 360, Suite 300
Grand Prairie, TX 75050

By signing this form, you are giving Amerigroup the right to get any of your medical records we need to look at for your appeal.

Your Signature: ____ Date: _____________
(Member or Parent/Guardian of child)

MF-TX-0038-17