AmeriHealth NEW JERSEY

Implant Reimbursement Request Form

Please complete the following fields and fax to 215-238-2544 or email to AHNJimplants@amerihealth.com.

Provider Name: _____

Provider #: _____

Member Name: _____

Member ID #: _____

Member Provider Account #: _____

Surgical Paid Claim #: _____

Admit Date: _____

Discharge Date: _____

Implant Type: _____

Implant Invoice Cost: _____