



Medicare Provider Appeal Process for Non-Contracted Providers

Medicare Advantage Organization

Filing a request for review of a denied claim

In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations governing the Medicare Advantage program, non-contracted providers, may request reconsideration of a Medicare Advantage plan denial of payment. Requests for reconsideration of a denied claim must be submitted within 60 days of the date of this remittance advice and a signed waiver of liability (WOL) statement is required by CMS. The form can be found at:

www.amerihealthnj.com

Requests for reconsideration of a denied claim must be submitted in writing and should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's disagreement for reimbursement. Once we receive the completed form, we will give you a decision on your appeal within 60 calendar days.

You may mail your written appeal to:

AH65 Provider – Appeals Unit

P.O. Box 7218

Philadelphia, PA 19101