



Provider Claim Inquiry Form

Reference #:
Date submitted:
Pages attached:

Inquiry type: Amount of payment questioned Denied claim questioned

To ensure that your request is handled promptly and accurately, please mail the completed form and supporting documentation to the address listed in the box below. If you do not include the claim number, then you must include the Provider Explanation of Benefits (EOB).

AmeriHealth New Jersey Provider Claim Inquiries
P.O. Box 7930
Philadelphia, PA 19101-7930

Note: If your office is registered with NaviNet®, please submit claim inquiries electronically.

Practice name:			Provider number/NPI:
Street address:			Name of contact person:
City:	State:	Zip:	Telephone number:

Member name:	Patient's name:
Member ID:	Check number:
Claim number:	Date of check or explanation:
Date of service:	Place of service:

PROVIDE DETAILED EXPLANATION FOR INQUIRY:

AmeriHealth New Jersey maintains processes to address and resolve provider inquiries and provider complaints related to the adjustment of claims. If you would like us to investigate the way we have processed a particular claim, please complete this form and send it to us, along with the EOB (or claim number) and any supporting documentation to the address above.

We will investigate your claims-related issue, process any required adjustments, or send you a written resolution letter regarding the processing of the claim. If you have any questions, please contact Customer Service at **1-888-YOUR-AH1 (1-888-968-7241)**.

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