ARC APPEAL REQUEST FORM

This form is for Authorization Related Claims Appeals only.

REQUEST TYPE	☐ Late Notification ☐ Lack of Supporting Documentation (including preliminary authorizations)	☐ Services Exceed Authorization ☐ Other reason not listed

DEMOGRAPHIC INFORMATION			
Authorization Number:			
Claim Number:		Date of Service(s):	
Member Name:		Date of Birth:	Member ID Number:
Provider or Facility:			
NPI:	TIN:		
Primary Contact:	Phone:	Fax (required):	Email (required):
Second Contact:	Phone:	Fax:	Email:

TYPE OF SUPPORTING DOCUMENTATION SUBMITTED:

- ☐ Proof of prior authorization (Must be a letter from IntegraNet or approval letter from Amerigroup)
- ☐ Discharge Summary, Medical Records, Clinical Documentation previously requested
- ☐ Other, please explain below:

Additional Details: