Amerigroup
District of Columbia

Enrollee Appeals Request Form

Thank you for choosing Amerigroup District of Columbia, Inc. as your health plan.
If you do not agree with a decision we made, please use this form to contact us.

Enrollee Name:

Parent or Guardian Name (if service is for a child):

Enrollee ID #:

Enrollee Date of Birth:

Name of Doctor Providing the Service:

Authorization Number:

Provider Address:

Provider Office Phone Number(s):

Type of Service You Want:

Reason for Requesting Service:

Date of Service Provided:

Authorized Person/Provider:

Reason for Appeal:

You can submit this form to the Appeals Department by:
Fax: **866-516-4806**
Email: **MedicaidDCGA@amerigroup.com**
Mail: Amerigroup District of Columbia, Inc.
Enrollee Appeals, P.O. Box 62429, Virginia Beach, VA 23466-2429

By signing, enrollee is providing approval for their provider or other chosen representative to act on their behalf in this appeal.

Signature:

Date:

myamerigroup.com/DC

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DHCF Department of Health Care Finance

WE ARE WASHINGTON GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

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