Emergency Room Review Form

Please complete the following information and attach this form with each Emergency Room Medical Record. Thank you!

Product (please circle one):

▪ AmeriHealth HMO   ▪ AmeriHealth Point-of-Service   ▪ AmeriHealth PPO

Provider Name: _____

NPI and/or 10-Digit Legacy Provider ID Number: _____

Patient ID Number: _____

Date of Service: _____

AmeriHealth Claim Number: _____

Patient's First Name: _____

Patient's Last Name: _____

_____   (_____) _____
Form completed by (print name)   Telephone number

Return completed form with medical records to:

Claims Medical Review - Emergency Room Review
AmeriHealth
1901 Market Street
Philadelphia, PA 19103-1480