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Aetna Better Health® of California

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT DURING THE DISPUTE RESOLUTION PROCESS.

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required. For the online editable form, use the tab key to move from field to field. Use the spacebar to check the appropriate boxes.
- Please complete this form if you are seeking reconsideration of a previous billing determination.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- In order to ensure the integrity of the Provider Dispute Resolution (PDR) process, we will re-categorize issues sent to us on a PDR form which are not true provider disputes (e.g., claims check tracers or a provider's submission of medical records after payment was denied due to a lack of documentation).
- For routine follow-up, please use the Claims Follow-Up Form.
- Mail the completed form to:

Aetna Better Health of California
Provider Disputes and Resolution Dept
PO Box 818096 Cleveland, OH 44181-8096

***PROVIDER NAME:**	***PROVIDER NPI #:**
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____ (please specify type of "other")

*** CLAIM INFORMATION** ☐ Single ☐ Substantially Similar Multiple Claims (complete attached spreadsheet)

*** Patient Name:**		**Date of Birth:**
*** Health Plan ID Number:**	**Patient Account Number:**	**Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Previous Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	**Title**	**( ) Phone Number**
Signature	**Date**	**( ) Fax Number**

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**
(Please do not staple additional information)

For Health Plan Use Only
TRACKING NUMBER
PROVIDER ID#

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For use with multiple "LIKE" claims (disputed for the same reason)

*PROVIDER NAME:	*PROVIDER NPI #:

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**
(Please do not staple additional information)