PAR Provider Dispute Form

If you are a PAR (Contracted) Provider, you may use this DISPUTE Form to have your claim reconsidered. Please be sure to fill this form out completely and accurately to ensure proper handling of your Dispute. NOTE: For faster processing, you may also submit your Dispute thru our Secure Provider Web Portal. Instructions can be found on our website at https://www.aetnabetterhealth.com/michigan/providers/portal.

Send To:
AETNA BETTER HEALTH OF MICHIGAN
Medicaid & Premier Plans
PO BOX 982963
El Paso, TX 79998-2963

Select the appropriate reason for your Dispute (Incomplete or missing information may cause Dispute decision to be upheld or returned to Provider):

- ☐ Incorrect Denial of Claim or Claim Line(s)
- ☐ Incorrect Denial of Authorization
- ☐ Code or Modifier Issue
- ☐ Medical Necessity
- ☐ Incorrect Rate Payment
- ☐ Other _____

Your Appeal Must Include:

- This Completed Form
- Factual or legal basis for appeal statement
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information (clinical records, required documentation, CMS or Medicaid references as needed, for Opt-Out members: EOB from primary Medicare payer, etc.)

You may use this form to supply necessary information, along with your attachments as indicated above, to enable a thorough reconsideration of all Appeals.

MI Plan being Disputed:	☐ Medicaid Only ☐ MI HealthLink (Duals)
Provider Name:	
Provider NPI Number:	
Submitter's name:	
Provider Street Address:	
Provider City, State & ZIP	
Provider Phone Number:	
Date(s) of Service:	
Remittance Advice Date:	
Amount Billed:	
Amount Paid:	
Claim Number(s):	
Member Name:	
Member ID #:	

Providers should always refer to the provider manual and their contract for further details. For general claims inquiry: please call 1-866-316-3784 Monday - Friday, 8:00 AM to 5:00PM EDT. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Relations Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.