Provider dispute form

Mail claim reconsiderations/dispute to:
Aetna Better Health - Provider Services Department
Attention: Provider Dispute
333 W. Wacker Drive
Suite 2100
Chicago, IL 60606

Provider information required

Provider name	
Submitter's name	
Provider Street Address	
Provider city, state, zip	
Provider phone number	
Provider alternative phone number	
Email	

Member information required

Member Name	
Member ID #	

Claim Dispute – If relation to claims dispute provide the following information

Date(s) of service	
Remittance advice date	
Amount billed	
Amount paid	
Claims number(s)	

Please use the space below to documents your dispute: Supply any other necessary information, along with attachments, to enable the thorough reconsideration of all disputes.

Signature of sender Date