



AETNA BETTER HEALTH® OF OHIO

Provider Dispute/Appeal Form

For contracted participating providers with Aetna Better Health of Ohio:

Revised Claims Resubmission and Reprocessing: A "resubmission" is defined as a claim originally denied because of missing information or incorrect coding that prevents Aetna Better Health from processing the claim.

Mark at the top of the claim "RESUBMISSION" and include the following:

- Statement indicating the correction or request
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Documentation supporting request
- Any additional information required to process the claim
- Any information should be submitted single sided

CLAIMS RESUBMISSION/RECONSIDERATION MUST BE SUBMITTED TO:

**AETNA BETTER HEALTH OF OHIO
P.O. BOX 64205
PHOENIX, AZ 85082**

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

Type of claim dispute (circle one)	Corrected Claim or Resubmission
Provider Name:	
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 #	

Rev. 3/2016

Providers should always refer to the provider manual and their contract for further details. For general claims inquiry: please call (855) 364-0974 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.



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Non- Par Providers: To Appeal a Claim Denial

If you are a provider **not contracted** with Aetna Better Health directly or through its subcontracted networks: If you do not agree with the claim decision, you have the right to appeal. You may submit an appeal for a claim denied based on error or absence of fact, except for timely filing. Federal regulations 42 CFR 42 § 422.504(g) requires us to protect Aetna Better Health members from financial liability, therefore, appeals must include a signed Waiver of Liability (WOL) form, (available at www.aetnabetterhealth.com/Ohio).

To appeal a claim denial, write a letter and mark the top of the request "appeal" and include the following:

- Statement indicating factual or legal basis for appeal
- A signed "Waiver of Liability"
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information, clinical records or documentation

APPEALS FOR NON-PAR PROVIDERS SHOULD BE SENT TO:

**AETNA BETTER HEALTH OF OHIO
ATTN: PROVIDER RELATIONS
7400 W. CAMPUS RD.
MAIL CODE: F494
NEW ALBANY, OHIO 43054**

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