Aetna Better Health® of Florida
261 N. University Drive
Plantation, FL 33324

AETNA BETTER HEALTH® OF FLORIDA

Claims Adjustment Request & Provider Claim Reconsideration Form

Aetna Better Health® of Florida is committed to delivering the highest quality and value possible. Below you will find two forms to help you with your claim questions and concerns.

You may use the Claims Adjustment Request Form for provider claims Inquiries and disputes concerning non-clinical denials and rate reimbursement disagreements; or the Provider Claim Reconsideration Form for the following reasons:

- Itemized Bill
- Duplicate Claim
- Corrected Claim (note “corrected” on claim)
- Coordination of Benefits (note “corrected” on claim)
- Proof of Timely Filing
- Claim/Coding Reconsideration
- Other Claim Reconsideration

Provider Claim Reconsideration Form

Please complete the information below in its entirety and mail with supporting documentation and a copy of your claim to the address listed at the bottom of this form. Questions regarding a submission should be directed to Claims Inquiry/Claims Research at **1-800-441-5501**. Please use one form per member.

Date: _____

MEMBER INFORMATION			
Member Name		Date of Service	
Patient Account Number		Billed Amount	
Member ID		Claim Number	

PROVIDER INFORMATION			
Provider Name		Tax ID Number	
Practice Name		NPI Number	
Street Address		Fax Number	
City/State/Zip		Contact Name	
Provider Phone Number		Contact Number	

SUBMISSION INFORMATION (See second page for detailed descriptions)

Claim Reconsideration
☐ Itemized Bill
☐ Duplicate Claim
☐ Corrected Claim (note “corrected” on claim)
☐ Coordination of Benefits (note “corrected” on claim)
☐ Proof of Timely Filing
☐ Claim/Coding Reconsideration
☐ Other Claim Reconsideration

If you checked a box above, please mail claim and all supporting documentation to:

Aetna Better Health of Florida
P.O. Box 982960
El Paso, TX 79998-2960

Examples of Appeals

- Prior-Authorization Appeal
- Level of Care Appeal
- Medical Necessity Appeal
- Payment Dispute
- Claim/Coding Edit Appeal
- Other Appeal Request

If any of the above apply, please do not use this form and fax or mail the Appeal and all supporting documentation clearly marked as “Appeal Request" to:

Aetna Better Health of Florida
PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Please indicate the reason for resubmission and any pertinent details regarding your claim below.

Claim/Reconsideration Descriptions
Itemized Bill • All claims associated with an Itemized Bill must be broken out per Rev code to verify charges billed on the UB match the charges billed on the Itemized Bill. (Please attach Itemized Bill that is broken out by Rev code with subtotals.)
Duplicate claim • Review request for a claim whose original reason for denial was "duplicate." • Provide documentation as to why the claim or service is not a duplicate such as medical records showing two services were performed.
Corrected Claim • The corrected claim must be clearly identified as a corrected claim by writing or stamping "corrected" on the claim itself.
Coordination of Benefits • Attach EOB or letter from primary carrier and forward to the Claims Department identifying as "corrected" claim.
Proof of Timely Filing • For electronically submitted claims provide the second level acceptance report. • Refer to Proof of Timely Filing Requirements in your Provider Manual.
Claim/Coding Edit • Aetna Better Health of Florida uses two (2) claims edit applications: Claim Check and iHealth. Please refer to the Provider Manual on the Aetna Better Health of Florida website, **www.AetnaBetterHealth.com/Florida**, for more information on claim editing.

Corrected claims must be received within 180 days of the date of service or discharge date. The only exception to this is Medicare

Appeals must be received within 180 days of the date of service or discharge or within 45 days of the action resulting in need to file the appeal.

Claims Adjustment Request Form

You may use this form for Provider Claims Inquiries and Disputes concerning non-clinical denials and rate reimbursement disagreements. This Claims Adjustment Request form does not initiate a Formal Claim Dispute and does not push back the deadline to file a written Formal Dispute, which is Step 1 of an official appeal and must be filed within 45 calendar days of original decision shown on your EOP/EOB. For more information, see Aetna Better Health of Florida's Provider Handbook.

With this Claims Adjustment Request Form include:
A copy of the EOP/EOB(s) with claim(s) to be reviewed clearly circled.

The form may be submitted via:

- **EMAIL**: FLAppealsandGrievances@AETNA.com
- **FAX**: 1-860-607-7894

IMPORTANT NOTICE
Aetna Better Health® of Florida's Provider Relations Department will make reasonable efforts to resolve this request within 30 calendar days of receipt. That resolution may be:

- Reprocessing your claim and issuing a new EOP with new payment information, or
- A determination that a formal dispute is required and issuing you a letter to that effect, or

A determination that reprocessing is not appropriate and issuing you a letter to that effect.

Aetna Better Health® of Florida is committed to protecting the privacy of our providers and members; hence it is important to submit this request in a secured manner.

Date of Request	
Requestor Name	
Requestor Phone Number	
Requestor Email Address	
Provider Tax ID	

*You may attach additional excel sheets if needed. You may submit this information on an electronic excel spreadsheet as long as the information above is included; this can be sent to: **FLAppealsandGrievances@AETNA.com**

Provider Name Last, First	Provider NPI #	Member Name	Member ID	Member DOB	Claim #	Date(s) of Service	Reason for Adjustment Request