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.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Please provide documents to support the dispute description. Do not include copies of previously processed claims.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Please mail the completed form to: Aetna Correspondence Unit
  P.O. Box 14020
  Lexington KY 40512

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

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

*** 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 Billing Determination
☐ Contract Dispute
☐ Other:

*** DISPUTE DESCRIPTION:**

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#

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

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)