Attachment B

# NON-PARTICIPATING PROVIDER PAYMENT DISPUTE FORM

This form should be used if you would like a claim reopened. This is not a formal appeal. Requests must be submitted within 60 days of the date of service. If the request is filed after the 60-day timeframe, please include your reason for not making this request earlier.

**Please complete one request form for each claim you are submitting for review.**

## The following criteria MUST be completed

Today's Date________________

Beneficiary Name: ____________________________________________________________

Medicare/Health Insurance Number: _______________________________________ Plan type: Medical

Provider Name: _____________________________ NPI/TIN:___________________________

Contact Name and Title: ______________________

Contact Address: _______________________________________ Contact Phone: ________________

Contact Fax: ________________ Contact Email: ___________________________

Original Claim Number: ________________________ Date of Service: ___________________________________

Initial Denial Notification Date: ________________

CPT/HCPC/Service Being Denied:_______________________________________________

Explanation of Your Request:

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

For Payment related disputes please submit to:

Aetnareconsiderations@carelon.com or P.O. Box 4491 Woodland Hills, CA 91365

For all other non-payment denials, please complete the Aetna "Non Participating Provider Complaint and Appeal Request Form" found on the Aetna website and along with the completed Waiver of Liability Statement and submit in writing to:

Medicare Provider Appeals
PO Box 14067
Lexington, KY 40512

Or Fax at: 1-724-741-4953

# WAIVER OF LIABILITY STATEMENT

| Claim #: |
|---|

| Enrollee's Name: | Member ID: |
|---|---|
| Provider: | Dates of Service: |
| Health Plan: | |

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

| Signature: | Date: |
|---|---|