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 365 days of the date of service. If the request is filed after the 365-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. Please include Hold Harmless Waiver with this form.

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 submit in writing to:

Medicare Provider Appeals
PO Box 14835
Lexington, KY 40512

Or Fax at: 1-860-900-7995

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: