PAR Provider Dispute

Participating Provider Claim Disputes

Aetna Assure Premier Plus (HMO D-SNP) and our participating providers are responsible for timely resolution of any disputes between both parties. Disputes, also known as reconsiderations, will be settled according to the terms of our contractual agreement and there will be no disruption or interference with the provision of services to enrollees as a result of disputes.

We will inform providers through the Provider Manual and other methods including provider Newsletters, trainings, provider orientation, webinars, the website, and through provider inquiries to their Provider Experience Representative about the claims dispute process.

Our Provider Experience Representatives are available to discuss a provider's dissatisfaction with a decision based on this policy and contractual provisions, inclusive of claim disputes.

To have a claim reconsidered through our claim dispute process for participating providers, the contracted provider may submit using one of two methods:

1. **The PAR Provider Claims Dispute Form**
   - This form is accessible on our website at www.aetnabetterhealth.com/new-jersey-hmosnp/providers
     under the 'Resources' link. A copy of the form is also located on the next page of this Orientation Kit.
   - Complete and submit the PAR Provider Claims Dispute Form along with the claim and any appropriate supporting documentation (if applicable) to:

     Aetna Assure Premier Plus
     P.O. Box 982967
     El Paso, TX 79998-2967

2. **Providers may also submit disputes electronically**
   - Please log into the Secure Provider Web Portal located on our website under the 'Resources' link at www.aetnabetterhealth.com/new-jersey-hmosnp/providers.
   - For instructions, please visit our website under the 'Resources' link, and scroll down to 'Portal access and information'. Here, you will find a PDF document under Online Provider Dispute Instructions to walk you through the process. You will also be required to upload any supporting documentation required for the reconsideration of your claim related to your Dispute.

Providers will be notified of the decision for a Claim Dispute via remit (along with claim edits and descriptions) for reprocessed claim, or if the Claim Dispute was incomplete, a communication will be sent to the provider indicating that the Dispute could not be processed and will need to be resubmitted.

Providers should always refer to the provider manual and their contract for further details. For general claims inquiry: please call 1-844-362-0934 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 Experience Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.

Proprietary

PAR Provider Dispute

If you are a PAR (Contracted) Provider, you may use this DISPUTE Form to have your claim reconsidered. Please be sure to fill this form out completely and accurately to ensure proper handling of your Dispute. *NOTE:* For faster processing, you may also submit your Dispute thru our Secure Provider Web Portal. Instructions can be found on our website at **AetnaBetterHealth.com/New-Jersey-hmosnp/providers/portal**

SEND TO:
Aetna Assure Premier Plus (HMO D-SNP)
P.O. Box 982967
El Paso, TX 79998-2967

Select the appropriate reason for your Dispute (Incomplete or missing information may result in your Dispute being returned or decision upheld):

☐ Incorrect Denial of Claim or Claim Line(s)	☐ Medical Necessity
☐ Incorrect Denial of Authorization	☐ Incorrect Rate Payment
☐ Code or Modifier Issue	☐ Other ________________________

Your Dispute Must Include:

- This Completed Form
- Factual or legal basis for dispute statement (separate page)
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information (clinical records, required documentation, CMS or Medicaid references as needed, for Opt-Out members: EOB from primary Medicare payer, copy of auth, etc.)

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

Provider Name:	
Provider NPI:	
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 #	

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