Aetna Better Health® of Texas

Claims Reconsideration Form

Complete this form and return to Aetna Better Health of Texas for processing your request.

Request for Reconsideration:
Please choose one of the following reasons:

- ☐ Corrected claim
- ☐ Itemized bill/medical records (in response to a claim denial)
- ☐ Other insurance/third-party liability information
- ☐ New Texas Provider Identifier (TPI) issues or re-attestation
- ☐ Other: _____

Provider Name*	Provider Tax ID*
Provider NPI*	Date of last Explanation of Payment*
Aetna Claim Number*	Dates of Service (provide a range if multiple claims)*
Member Name*	Member ID*

(*Indicates a required field)

Attach all documentation and return to:

Aetna Better Health of Texas
PO Box 982964
El Paso, TX 79998-2964

Requested by: _____
Phone Number: _____
Date: _____