

# PAR Provider Dispute Form



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/ohio-hmosnp/providers/forms](http://aetnabetterhealth.com/ohio-hmosnp/providers/forms).

**Send To:**  
**AETNA BETTER HEALTH OF OHIO**  
**DUAL PREFERRED**  
**P.O. BOX 64205**  
**PHOENIX, AZ 85082**

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

- |   |   |
|---|---|
| <input type="checkbox"/> Incorrect Denial of Claim or Claim Line(s) | <input type="checkbox"/> Medical Necessity      |
| <input type="checkbox"/> Incorrect Denial of Authorized Service     | <input type="checkbox"/> Incorrect Rate Payment |
| <input type="checkbox"/> Code or Modifier Issue                     | <input type="checkbox"/> Other _____            |

**Your Dispute Must Include:**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• This Completed Form</li> <li>• Factual or legal basis for dispute statement (separate page)</li> <li>• Copy of the original claim</li> </ul> | <ul style="list-style-type: none"> <li>• Copy of the remit notice showing the claim denial</li> <li>• 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.)</li> </ul> |
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You may use this form to supply necessary information, along with your attachments as indicated above, to enable a thorough reconsideration of all disputes.

<b>Provider Name:</b>	
<b>Provider NPI:</b>	
<b>Submitter's name:</b>	
<b>Provider Street Address:</b>	
<b>Provider City, State &amp; ZIP</b>	
<b>Provider Phone Number:</b>	
<b>Date(s) of Service:</b>	
<b>Remittance Advice Date:</b>	
<b>Amount Billed:</b>	
<b>Amount Paid:</b>	
<b>Claim Number(s):</b>	
<b>Member Name:</b>	
<b>Member ID #:</b>	

Providers should always refer to the provider manual and their contract for further details. For general claims inquiry: please call 1-800-260-3166 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 Relations Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.