Aetna Better Health® Kentucky

Claim Reconsideration Request

The Claim Reconsideration option allows providers to request a review of a previously processed and finalized claim for certain non-clinical issues. This includes requests related to non-clinical denials, missing or corrected information, and reimbursement rate concerns.

We are actively working toward expanded electronic capabilities and encourage providers to begin using this updated submission method now. This process is intended for inquiries related to a claim that has already been processed.

Using this submission process allows you to:

- Submit all issues for a single claim in one request.
- Include all supporting documentation at the time of submission.
- Ensure visibility of submitted information across appropriate teams.

Important reminders:

- Submit one form per claim. More than 3 claims require the spreadsheet format. See below or email to request a copy.
- Required fields are marked with an asterisk (*).
- Be specific and include relevant details to support your request.
- Do not use this form for formal appeals—please continue to follow your standard appeals process.

Managing Claims	
Corrected Claim	A claim has been previously submitted and adjudicated and is being resubmitted by the provider due to an error or omission. A corrected claim allows the provider to submit the claim with additional corrected information.
Claim Reconsideration	A claim reconsideration is a request by a provider to have ABHKY review a claim that was previously paid, denied or reduced.
Claims Appeal	A provider appeal/dispute is the adjustment request of the processing, payment or nonpayment of a claim by ABHKY

Timely Filing Guidelines	
The guidelines below are applicable unless otherwise specified in your provider contract.	
Initial Claims	365 Days from the date of service
Claim Corrections	24 Months from the date of the Provider Remittance
Claim Appeals	365 Days from the date of notification

Provider Claim Resubmission Form **Date: _____**

Complete the information below in its entirety and email with supporting documentation to the following email address:

Aetna Better Health of Kentucky KYProviderRelations@aetna.com

Questions regarding a submission should be directed to Claims Inquiry/Claims Research at **1-800-300-5528**. Use one form per member.

PROVIDER INFORMATION			
Provider Name *		Tax ID Number *	
Practice Name		NPI Number *	
Contact Name *		Contact Email and phone *	
Provider Type:			
MEMBER INFORMATION			
Member Name		Date of Birth	
Member ID		Patient Account Number	

CLAIM INFORMATION			
Claim Information Number of Claims	☐ Single ☐ Multiple "Same Issues" Claims (attach spreadsheet)		
ClaimNumber		Billed Amount	
DOS Start		DOS End	
☐ Itemized Bill	☐ Proof of Timely Filing	☐ Claim/Coding Edit	
☐ Duplicate Claim	☐ Coordination of Benefits	☐ Corrected Claim	
☐ Rate Dispute	☐ Denied Line	☐ Other (explain in comments)	
Expected payment or outcome.			

Indicate the reason for resubmission and any pertinent details regarding your claim below:

Multiple Claim Submission (Excel File Option)

If you are submitting reconsideration requests for multiple claims, you may upload a single Excel file in place of individual forms. To ensure timely and accurate review, your Excel file must include the following column headers and required information:

Column Name	Description / Requirement
Unique Reference Number (if available)	Unique reference generated from a prior submission (e.g., Contact Center, Availity, Appeal). Not required but should be included if available.
Provider Name	Legal name of the billing provider or facility. Must match the name submitted on the claim.
Provider NPI	National Provider Identifier associated with the claim. Required to validate provider enrollment and contract alignment.
Group/Practice Name	Billing group or practice name, if different from the provider name. Used for aggregation and contract interpretation.
Group/Practice Tax ID	Tax Identification Number (TIN) associated with the claim. Required to validate reimbursement terms.
Patient Name	Full patient name as submitted on the claim. Used for claim matching and eligibility validation.
Member ID	Aetna Better Health of Kentucky member ID. Required for eligibility and benefit validation.
Patient DOB	Patient's date of birth. Used to confirm member identity and resolve mismatches.
Patient Account Number	Provider's internal account or billing number. Optional; used for provider reconciliation.
Claim Number	Aetna claim number assigned during adjudication. Primary identifier for processing.
Date of Service Start	Date services began. Used to evaluate eligibility, authorization, and timely filing.
Date of Service End	Date services ended. Used in conjunction with start date for review validation.
Billed Amount	Total amount billed by the provider. Required for comparison against payment and contract terms.
Expected Reimbursement	Amount the provider believes should have been paid based on contract terms, fee schedule, or authorization. Used as a reference only and not a guarantee of payment.
Denial Reason on the Claim	Denial or adjustment reason code and description from the remit
Detailed Description of Issue	Explanation of why the claim should be reconsidered. Must include what is incorrect, why it is incorrect, and any supporting context.

Important Notes

All fields should be completed to the extent possible to avoid processing delays. Incomplete or unclear submissions may be returned for additional information.

Submission of an Excel file does not guarantee payment or overturn of the original determination; all requests will be reviewed in accordance with applicable contract terms, policies, and regulatory requirements.

You may fax this information to 855-454-5584 but this may cause a delay in processing.