Aetna Better Health® of Virginia
PO Box 818044
Cleveland, OH 44181-8044

Aetna Better Health® of Virginia

Provider Claim Resubmission Instructions and Form and Appeal Request Instructions and Form

Aetna Better Health of Virginia is committed to delivering the highest quality and value possible. Below, you will find two forms to help you with your claim questions and concerns.

Provider Claim Resubmission Instructions
You may use this form for provider claim issues concerning nonclinical denials, missing information or a correction, and/or rate reimbursement disagreements.

Use this *Provider Claim Resubmission Form* for the following reasons:

- **Itemized Bill** (mark the top of the claim "CLAIM FOR RESUBMISSION")
  - Must be received within 35 days after receipt of the notification
  - All claims associated with an Itemized Bill must be broken out per Rev Code to verify charges billed on the UB match the charges billed on the Itemized Bill. (Attach I-Bill that is broken out by rev code with sub-totals.)
- **Duplicate Claim** (mark the top of the claim "CLAIM FOR RESUBMISSION")
  - Review request for a claim whose original reason for denial was "duplicate"
  - Provide documentation as to why the claim or service is not a duplicate such as medical records showing two services were performed
- **Proof of Timely Filing** (mark the top of the claim "CLAIM FOR RESUBMISSION")
  - For electronically submitted claims provide the second level of acceptance report
  - Refer to Proof of Timely Filing Requirements in the Provider Manual
- **Coordination of Benefits** (mark the top of the claim "CLAIM FOR RESUBMISSION")
  - Must be received within 90 days after final determination
  - Attach EOB or letter from primary carrier
- **Claim/Coding Edit** (mark the top of the claim "CLAIM FOR RESUBMISSION")
  - We use two claims edit applications: Claim Check and Cotiviti.
  - Refer to the Provider Manual for details.
- **Corrected Claim** (mark the top of the claim "CORRECTED CLAIM FOR RESUBMISSION")
  - Must be received within 365 days of the date of service or discharge date
  - Newly added modifier
  - Code changes
  - Any change to the original claim

To resubmit a claim with missing information or a correction, mail claim and all supporting documentation appropriately labeled to the address specified on the form.

Note: Provider Claim Resubmissions do not include pre-service denials that were denied due to not meeting medical necessity. Pre-service denials are processed as member appeals and are subject to member policies and timeframes.

Provider Claim Resubmission Form **Date: _____**

Complete the information below in its entirety and mail with supporting documentation and a copy of your claim to the following address:

Aetna Better Health of Virginia
PO Box 982974
El Paso, TX 79998-2960

Questions regarding a submission should be directed to Claims Inquiry/Claims Research at **1-800-279-1878**. Use one form per member.

MEMBER INFORMATION			
Member Name		Date of Service	
Patient Account Number		Billed Amount	
Member ID		Claim Number	
PROVIDER INFORMATION			
Provider Name		Tax ID Number	
Practice Name		NPI Number	
Street Address		Fax Number	
City/State/ZIP		Contact Name	
Provider Phone Number		Contact Number	

RESUBMISSION INFORMATION (Include additional pages if needed.)		
Claim Resubmission		
☐ Itemized Bill	☐ Proof of Timely Filing	☐ Claim/Coding Edit
☐ Duplicate Claim	☐ Coordination of Benefits	☐ Corrected Claim

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

_____

_____

_____

_____

_____

Aetna Better Health® of Virginia
PO Box 818044
Cleveland, OH 44181-8044

Appeal Request Instructions

Use this *Provider Claim Appeal* form for provider claim appeals concerning claim denials and claim payment amounts that are not related to a resubmission. See *Provider Claim Resubmission Instructions.* Claim appeals must be received within 60 days of the action resulting in need to file the appeal. For more information, refer to the Provider Manual.

Your request for appeal should include the form along with medical records to support your request. Do not submit the member's entire medical record. **Only submit the medical records relevant to your request and indicate which pages support your request.** Submit your appeal through the option that is convenient for you:

Aetna Better Health of Virginia
PO Box 81040
5801 Postal Road
Cleveland, OH 44181
Email: VAGrievanceandAppeal@Aetna.com
Fax: 1-866-669-2459
Availity Provider Portal

Aetna Better Health of Virginia will make reasonable efforts to resolve this request within 30 calendar days of receipt.

Provider Claim Appeal Form **Date: _____**

Complete the information below in its entirety and submit it with supporting clinical documentation to the Cleveland, OH address listed in the instructions. Questions regarding the appeal should be directed to Claims Inquiry/Claims Research at **1-800-279-1878**. Use one form per member.

MEMBER INFORMATION			
Member Name		Date of Service	
Patient Account Number		Billed Amount	
Member ID		Claim Number	
PROVIDER INFORMATION			
Provider Name		Tax ID Number	
Practice Name		NPI Number	
Street Address		Fax Number	
City/State/ZIP		Contact Name	
Provider Phone Number		Contact Number	

APPEAL INFORMATION (Include additional pages if needed.)

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

_____

_____

_____

_____

_____

_____