Non-PAR Provider Appeals Form

Send To:
Aetna Assure Premier Plus
(HMO D-SNP)
ATTN:Grievance&Appeals
PO Box 818070
Cleveland, OH 44181

If you are a non-PAR (not contracted) Provider (either directly or through its subcontracted networks) you have the right to appeal the claim decision. You may submit an appeal for a claim denied or not paid as expected based on error or absence of fact, except for timely filing. Federal regulations 42 CFR 42 § 422.504(g) requires us to protect Aetna Assure Premier Plus (HMO D-SNP) members from financial liability. Therefore, appeals must include a signed Waiver of Liability (WOL) form, (available at AetnaBetterHealth.com/New-Jersey-hmosnp/providers/forms).

Select the appropriate reason for your Appeal (Incomplete or missing information may cause Appeal decision to be upheld or returned to Provider):

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

Your Appeal Must Include:

- This Completed Form
- Factual or legal basis for appeal statement
- A signed "Waiver of Liability"
- 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, etc.)

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

Provider Name:	
Provider NPI Number:	
Submitter's name:	
Provider StreetAddress:	
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 #:	

Providers should always refer to the provider manual and their contract for further details. For general claims inquiry: please call 1-844-362-0934 (TTY: 711), 8:00 AM to 8:00PM EDT, 7 days a week. 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.

NJ-20-08-42