Aetna Billing Dispute Resolution Request Form

PLEASE NOTE THAT IF THIS DISPUTE PERTAINS TO SERVICES RENDERED BEFORE 11/06/03 YOU SHOULD SUBMIT A "RETAINED CLAIMS EXTERNAL BILLING DISPUTE REQUEST FORM"

IF THIS DISPUTE PERTAINS TO AETNA'S MEDICAL RECORDS SUBMISSION REQUIREMENT YOU SHOULD SUBMIT A "REQUEST FOR DISPUTE OF MEDICAL RECORDS SUBMISSION REQUIREMENT FORM"

The Billing Dispute Resolution Process is available to resolve disputes over the application of coding and payment rules and methodologies to patient's specific factual situations or to resolve disputes over any requirement by Aetna that a physician or physician group routinely submit medical records in order to obtain payment.

Please note that physicians and physicians' groups must exhaust Aetna's internal appeal process before submitting a billing dispute for external review. Physicians and physicians' groups are deemed by implication to have exhausted Aetna's internal appeals process if Aetna does not communicate a notice of decision within forty-five (45) calendar days from the receipt of all documentation needed to complete the internal appeal ("implied exhaustion"). Physicians and physicians' groups must submit this request within ninety (90) calendar days of receipt of Aetna's notice of decision.

Please note that you must include the appropriate filing fee with this form.

Instructions - Make Sure the Submission Meets the Requirements Set Forth Below

Exhaustion of Internal Appeals: You must be able to answer "Yes" to one of the questions listed below.

A. (1) Were you notified by Aetna that the internal appeals process was exhausted?

Yes_____ No_____

(2) Has Aetna failed to communicate a notice of decision within forty-five (45) calendar days from Aetna's receipt of all documentation needed to complete your internal appeal?

Yes____ No_____

Deadline for Filing: **You must be able to answer "Yes" to this question.**

B. Will this request be **received** within ninety (90) calendar days of Aetna's notification?

Yes_____ No_____

Amount in Dispute: **The amount in dispute (the additional amount you believe Aetna should have paid) of the single or multiple claims must be more than $500**.

C. (1) Is the amount of the single or multiple claim(s) in dispute more than $500?

Yes_____ No_____

(2) If you answered "No" to "C(1)", have you previously filed and deferred consideration of similar claims within one (1) year and if so does the filing of this claim result in an aggregate amount of greater than $500?

Yes_____ No_____

(3) If you answered "No" to "C(2)" would you like this request to be deferred?

Yes_____ No_____

All supporting documentation that the physician or physician's group wishes to be considered by the External Review Officer must be attached to this form. You do not have to resubmit the documentation that you have already submitted to Aetna pursuant to the internal appeals process. Aetna will forward that documentation to IMEDECS, who will in turn forward you a complete list of materials it has received from Aetna so that you can confirm that the file is complete.

SEND THIS COMPLETED FORM, ALL SUPPORTING DOCUMENTATION AND THE FILING FEE TO:

IMEDECS
157 S. Broad Street
Suite 400
Lansdale, PA 19446
Phone: 215.855.0615
Fax: 215.855.5318

Physician Information

Treating Physician Name (as submitted on claim)	Tax Identification Number (as submitted on claim)	
Billing Address (Street, City, State, ZIP)		
Telephone Number Office ( ) ext.	Fax Number Office ( )	
Contact Name	Contact Phone Number	Contact E-mail

Claim Information

Member Name	Member ID Number	Member Group Number
Member Address (Street, City, State, ZIP)		

Request for Physician Billing Dispute

Date of Service:	Case Number (indicated on Aetna's appeal letter)
Amount In Dispute - The additional amount that you believe Aetna should have paid on the claim(s) in dispute: $	Filing fee: (Please check one) _____ $50.00 - Claim amount between $500.00 - $1,000.00 _____ $50.00 +5% of amount of dispute which exceeds $1000.00 _____ No amount is enclosed because this claim is an aggregate of a deferred claim. Amount enclosed: _____ Make check payable to IMEDECS
The decision of the ERO is final and binding on Aetna and the physician and/or physician group only with respect to the specific case being reviewed by the ERO. Participating providers may access Aetna's physician website for further information.	
Comments:	
I hereby acknowledge the terms of the External Billing Dispute Resolution Review and further certify the accuracy of the material and information submitted with the request: Signature of Physician: Date:	