aetna®

Aetna Better Health®
of Kentucky

Commercial Insurance Coverage Provider Attestation Form

(Use in lieu of EOB for Coordination of Benefits)

Provider Name: _____

Provider Medicaid ID: _____ Provider NPI: _____

Member Name: _____

Member Medicaid ID: _____ Member DOB: _____

Member Address: _____

From Date of Service: _____ To Date of Service: _____

Primary Insurance Carrier Name: _____

Address: _____

Policy Number: _____

Start Date: _____ End Date: _____

Date Primary Commercial Insurance Filed *(form will NOT be accepted without filing date)*: _____

Date of Primary Insurance Denial: _____

OR Indicate with an "X" No Response from Other Insurance (must exceed 120 Days from Filing date): _____

Provider Billing Office Contact Name: _____

Contact Phone Number: _____

Signature (*form will NOT be accepted without signature*): _____

Date: _____

NOTICE: This form is in lieu of EOB; EOB will also be accepted

Return this form to:
ATTN: Aetna Better Health of Kentucky
P.O. Box 982969
El Paso, TX 79998-2969