Aetna Better Health® of Louisiana

Independent Review Provider Reconsideration Request Form

Please return completed form by mail or email to:

Aetna Better Health of Louisiana
Attention: Independent Review
Reconsideration Request
P.O. Box 81040, 5801 Postal Rd.
Cleveland, OH 44181
independentreviewrequest@aetna.com

From: _____

Telephone #: _____

Email: _____

Fax #:_____

Required Information

Member Name: _____ Member ID #: _____

Date (s) of Service: _____ Remittance Advice Date: _____

Amount Billed: _____ Amount Paid: _____

Claim #: _____ Pended Claim: ☐ Yes ☐ No

Denial reason: _____ Denial Code: _____

Procedure Codes Billed: _____

_____

To request reconsideration, providers have 180 days from the date a claim denied in whole, partially or recoupment date of a claim or the MCO failed to issue a RA within 60 calendar days. Please use the space below to provide reason for dispute and any other necessary information, along with your attachments, to enable a thorough reconsideration.

Signature: _____ Date: _____

The MCO shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with R.S. 46.460.81, within 5 calendar days after the receipt of the request, and render a final decision by providing a response to the provider within 45 calendar days from the date of the receipt of the request for reconsideration, unless another time frame is agreed upon in writing by the provider and the MCO.