Dispute and Appeal Redefinitions

July 1, 2019

Dear Provider,

Aetna Better Health of Michigan will be updating our Provider Manual and Website to provide clearer understanding and instruction to our providers related to the various Dispute / Appeal / Grievance processes that are available to you. **These updates apply to BOTH our MI HealthLink Duals product & our Medicaid product.** Below is a summary of the updates:

Claim Reconsiderations –*ABHM will REQUIRE providers to use the new PAR and non-PAR forms on our website starting 8-1-19.*

Reconsideration Type	Who Uses	Address to Send	Where to find	Other Required Info
Dispute	Contracted (PAR) Providers	AETNA BETTER HEALTH OF MI Medicaid & Premier Plans PO Box 66215 Phoenix, AZ 85042	***(Paper Form)** on Website under the 'For Providers' section of our site, and under the banner 'Forms' - click link *'Par Provider Dispute Form'* ***(Provider Portal)** User guide available on website	***(Paper)** requirements as outlined on the form ***(Online)** complete all fields of information and attach supporting documentation
Appeal	Non-Contracted (Non-PAR) Providers	AETNA BETTER HEALTH OF MI PO Box 81040 5801 Postal Road Cleveland, OH 44181	***(Paper Form)** on Website under the 'For Providers' section of our site, and under the banner 'Forms' = click link 'non-Par Provider Appeal form'	For Denied Claims only, Appeal must be submitted with a completed 'Waiver of Liability' form available at same website location

Pre-Service Authorization Member Appeals

- ***On or before August 1st, 2019***, our provider manual will be refreshed to include more information related to this type of pre-claim Appeal to help providers better distinguish between this type Member Appeal that can be filed by a Provider on a Member's behalf, and a Claims Appeal with is for non-PAR providers to have a claim reconsidered. *Note*: Details on what to submit on behalf of a member for a Pre-Service Authorization Member Appeal is articulated in the Authorization Denial letter that is sent out by our UM staff after the decision is made to deny the claim.

Provider Grievances

- ***On or before August 1st, 2019***, our provider manual will be refreshed to include updated language related to a Provider Grievance, to help distinguish when this process is used. In general, a Provider Grievance is used when a provider has a concern related to an overall policy or procedure, unlike a Provider Dispute or Appeal which is specific to a Claim reconsideration.

We hope these reminders & updates allow you and your staff to better navigate the resources that are available. Our goal is to ensure your needs are being addressed appropriately and in a timely fashion. Should you have any questions, please contact us at 866-314-3784.

Sincerely,

Aetna Better Health of MI - Provider Experience Team