aetna®

Employee Assistance Plan (EAP) Provider Dispute Resolution Request

NOTE: BY VIRTUE OF YOUR EMPLOYEE ASSISTANCE PLAN (EAP) PROVIDER CONTRACT, YOU HAVE AGREED NEVER TO BILL AN EAP MEMBER FOR ANY EAP SERVICES.

INSTRUCTIONS

- Please complete this form. **Fields with an asterisk (*) are required**.
- Be specific when completing the Description of Dispute and Expected Outcome.
- Please provide documents to support the dispute description. Do not include copies of previously processed claims.
- Please mail the completed form to: **Aetna EAP Provider Payments**
  PO Box 981259
  El Paso, TX 79998-1259
- Or fax to: **800-935-0099**

***Provider Name**	***Provider Tax ID Number**
Provider Address	

***Claim Information** ☐ Single ☐ Substantially Similar Multiple Claims *(Complete attached spreadsheet.)*

***Member Name**	
Date of Birth (MM/DD/YYYY)	***Claim ID Number**
***Service "From/To" Date (Required for Claim, Billing, and Reimbursement of Overpayment Disputes)**	
Original Claim Amount Billed	**Original Claim Amount Paid**

Dispute Type

☐ Claim ☐ Request For Reimbursement Of Overpayment ☐ Seeking Resolution of a Billing Determination

☐ Other _____

***Dispute Description**

Expected Outcome

Contact Name (please print)	Title
Telephone Number (include area code)	Fax Number (include area code)
Signature	Date

☐ **Check Here If Additional Information Is Attached (Please do not staple additional information.)**

For Health Plan Use Only
Tracking Number
Provider ID Number

*Provider Name	*Provider Tax ID Number
Provider Address	

Number	*Member Name		Date of Birth	Authorization Number	*Original Claim ID Number	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
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☐ **Check Here If Additional Information Is Attached (Please do not staple additional information.)**