

Request for an Appeal of an Aetna Medicare Advantage Plan Authorization Denial

Because Aetna (or one of our delegates) denied your request for coverage of medical benefits, you have the right to ask us for an appeal of our decision. You have 60 calendar days from the date of your denial to ask us for an appeal. This form may be sent to us by mail or fax:

Address:

Fax Number:

Aetna Medicare Appeals & Grievances PO Box 14067 Lexington, KY 40512

1-724-741-4953

Date of Birth

You may also ask us for an appeal through our website at **www.aetnamedicare.com**. Expedited appeal requests can be made by phone at **1-800-932-2159**.

Who may make a request: Your doctor may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us at 1-800-282-5366, (TTY 711), 8 a.m. to 8 p.m., Monday through Sunday to learn how to name a representative.

Enrollee's Information

Enrollee's Name

Enrollee's Address			
City	State	ZIP Code	
Phone	Enrollee's Plan ID Number		
()			
Complete the following section ONLY if the person making this request is not the enrollee:			
Requestor's Name	Requestor's Relationship to Enrollee		
Address			
City	State	ZIP Code	
Phone			
()			
Representation documentation for appeal requests made by someone other than enrollee			
or the enrollee's doctor: Attach documentation showing the authority to represent the enrollee			
(a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more			
information on appointing a representative, contact your plan or 1-800-Medicare 24 hours a day, 7			
days a week. TTY users should call 1-877-486-2048.			

Important Note: Expedited Decisions	
If you or your doctor believes that waiting 30 calendar days for a st harm your life, health, or ability to regain maximum function, you decision. If your doctor indicates that waiting 30 calendar days couwe will automatically give you a decision within 72 hours. If you do support for an expedited appeal, we will decide if your case require	can ask for an expedited (fast) uld seriously harm your health, o not obtain your doctor's
CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WI supporting statement from your doctor, attach it to this re	THIN 72 HOURS. If you have a
Please explain your reasons for appealing.	
Attach additional pages, if necessary. Attach any additional inform case, such as a statement from your doctor and relevant medical r the explanation we provided in your denial.	
Signature of person requesting the appeal (the enrollee, or the enrollee's doctor or representative)	Date