

## Aetna Medicare Plans Complaint and Appeal Form

This form is for your use in making suggestions, filing a formal complaint, grievance, or appeal regarding any aspect of the service provided to you. We **are required by law** to respond to your complaints or appeals, and a detailed procedure exists for resolving these situations. If you have any questions, please feel free to call our Customer Services department at the number on your Member ID card, 8 a.m. to 8 p.m. Monday through Sunday and a representative will be available to assist you.

**Please print or type the following information:**

Member Name (Last, first, middle initial) M  F  / /  
(Male/Female) Date of Birth

Address Home Phone Number

City, State, Zip Work Phone Number

Name of Employer or Group (if applicable) Enrollment ID # Medicare ID# (Required if a Representative is elected)

*Authorized Representative: If the complaint is filed by someone other than the member, please review the section called "Who may file an Appeal" or "Who may file a Complaint" and provide the following information:*

Name: \_\_\_\_\_ Telephone # \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The representative designated above is authorized to act on my behalf for appeals and/or complaints related to Medicare Advantage plan benefits and/or Medicare prescription drug plan benefits. I authorized this individual to make any request; to present or to elicit evidence; to obtain complaint or appeals information; and to receive notice in connection with my complaint or appeal. I understand that personal medical information related to my complaint or appeal may be disclosed to the representative indicated above.

Please state the nature of the complaint, giving dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your complaint or appeal.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please sign and MAIL TO your health plan (see page #5 for health plan addresses)

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Date** \_\_\_\_\_ **Signature of Representative** \_\_\_\_\_

## **You may have the right to appeal.**

To exercise your appeal rights, file your appeal in writing within 60 calendar days after the date of your original denial notice. Your plan can give you more time if you have a good reason for missing the deadline.

### **Who May File An Appeal?**

You or someone you name to act for you (your **authorized representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others, not previously mentioned may already be authorized under State law to act for you.

You can call us at: 1-(800)-282-5366 (Aetna Medicare Advantage Plans) [or 877-238-6211 for Aetna Medicare Rx<sup>SM</sup> Plans] to learn how to name your authorized representative.

If you have a hearing or speech impairment, please call us at TTY/ TDD 1-(800)-628-3323 (Aetna Medicare Advantage Plans) [or 1-888-760-4748 for Aetna Medicare Rx<sup>SM</sup> Plans].

If you want someone to act for you, you and your authorized representative should sign, date, and send us page one of this form to serve as a statement naming that person to act for you. Your Medicare identification number must be reflected when naming a person to act for you.

### **What Do I Include With My Appeal?**

You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why your plan should provide the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

### **What Happens Next?**

If you appeal, we will review the decision. If any of the services you requested are still denied after our review, Medicare will provide you with a new and impartial review of your case by a reviewer outside of our Medicare Advantage Organization or Prescription Drug Plan. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

### **Other Contact Information:**

If you need information or help, call us at: 1-800-282-5366 (Aetna Medicare Advantage Plans) [or 877-238-6211 for Aetna Medicare Rx<sup>SM</sup> Plans]

### **Other Resources to Help You:**

Medicare Rights Center:

Toll Free: 1-888-HMO-9050

TTY/TTD: 1-877-486-2048

### **Elder Care Locator**

Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)

TTY/TTD: 1-877-486-2048

## IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

*For more information about your appeal rights, call your plan or see your Evidence of Coverage*

Any issue involving Medicare Advantage Plan Coverage	Any issue involving Prescription Drug Plan Coverage
<p><b>There Are Three Kinds of Appeals You Can File:</b></p> <p><b>Standard (30 days)</b> – If the denial is for a service, you can ask for a standard appeal. We must give you a decision no later than 30 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)</p> <p><b>Standard (60 days)</b> – If the denial is for a denied claim, you can ask for a standard appeal. We must give you a decision no later than 60 days after we get your appeal.</p> <p><b>Expedited (72-hour review)</b> - You can ask for an expedited appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. We must decide on an expedited appeal no later than 72 hours after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)</p> <ul style="list-style-type: none"> <li>• If any doctor asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, we will automatically give you an expedited appeal.</li> <li>• If you ask for an expedited appeal without support from a doctor, we will decide if your health requires an expedited appeal. If we do not give you an expedited appeal, we will decide your appeal within 30 days.</li> </ul>	<p><b>There Are Three Kinds of Appeals You Can File:</b></p> <p><b>Standard (7 Days)</b> – If the denial is for coverage of a prescription drug, you can ask for a standard appeal. We must give you a decision no later than 7 days after it gets your appeal request.</p> <p><b>Standard (7 Days)</b> – If the denial is for payment of a prescription drug, you can ask for a standard appeal. We must give you a decision no later than 7 days after we get your appeal.</p> <p><b>Expedited (72-hour review)</b> – You can ask for an expedited appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. We must decide on an expedited appeal no later than 72 hours after we get your appeal.</p> <ul style="list-style-type: none"> <li>• If any doctor asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 days could seriously harm your health, we will automatically give you an expedited appeal.</li> <li>• If you ask for an expedited appeal without support from a doctor, we will decide if your health requires an expedited appeal. If we do not give you an expedited appeal, we will decide your appeal within 7 days.</li> <li>• Your appeal will not be expedited if you've already received the drug you are appealing.</li> </ul>

## You have the right to file a complaint

You may file a written complaint, also known as a grievance, within 60 days after the date of the event out of which the grievance arises.

You may also file a Medicare Advantage expedited grievance, meaning your grievance will be decided within 24 hours in the following situations:

- If you disagree with our refusal to grant an expedited request for an organization determination or appeal.
- If you disagree with our decision to invoke an extension relating to an organization determination or appeal.

For grievances relating to the Prescription Drug Plan, you have the right to ask for a expedited grievance, meaning your grievance will be decided within 24 hours in the following situation:

- If you disagree with our refusal to grant an expedited request for an organization determination or appeal

### Who May File a Complaint?

You or someone you name to act for you (your **authorized representative**) may file a complaint. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others, not previously mentioned may already be authorized under State law to act for you.

You can call us at: 1-(800)-282-5366 (Aetna Medicare Advantage Plans) [or 877-238-6211 for Aetna Medicare Rx<sup>SM</sup> Plans] to learn how to name your authorized representative.

If you have a hearing or speech impairment, please call us at TTY/TDD 1-(800)-628-3323 (Aetna Medicare Advantage Plans) [or 1-888-760-4748 for Aetna Medicare Rx<sup>SM</sup> Plans].

If you want someone to act for you, you and your authorized representative should sign, date, and send us page one of this form to serve as a statement naming that person to act for you. Your Medicare identification number must be reflected when naming a person to act for you.

### What Do I Include With My Complaint?

You should include: your name, address, Member ID number, reasons for the complaint, and any evidence you wish to attach.

### What Happens Next?

We will review and decide the grievance within 30 days of receipt unless additional information necessary to resolve the grievance is not received during such time, or by mutual written agreement. You will receive a written notice stating the result(s) of the review.

## How You Can Reach Us

---

### For complaints or appeals about your Medicare Advantage Plan

**Write to:**

**Address:** Aetna  
Attn: Medicare Grievance & Appeals Unit  
P.O. Box 14067  
Lexington, KY 40512

**Telephone:** Expedited Appeals: 1-800-932-2159  
Grievances: 1-800-282-5366

**Fax Numbers:** 1-866-604-7091

---

### For complaints or appeals about your Prescription Drug Plan

**Write to:**

**Address:** Aetna  
Medicare Pharmacy Grievance and Appeal Unit  
P.O. Box 14579  
Lexington, KY 40512

**Telephone:** Expedited Appeals: 1-877-235-3755  
Grievances: 1-800-282-5366

**Fax Number:** 1-866-604-7092

---