Aetna Medicare Grievance Form

A grievance is a type of complaint. You may make it about us, or it may include one of our network providers or pharmacies or the quality of your care. This type of complaint does not involve coverage or payment determinations. You may file a written grievance within 60 days after the date the grievance event occurred.

This form may be sent to us by mail or fax:

Aetna Medicare Advantage Plan
Aetna Medicare Grievances
PO Box 14834
Lexington, KY 40512

Fax Number:
1-724-741-4956

You may also submit a complaint by contacting us:

- At the phone number on your ID Card and speaking with a Member Services representative
- Through our website at **www.aetnamedicare.com.**

Who may file a grievance: If you want another individual (such as a family member or friend) to file a grievance for you, that individual must be your representative. Contact us at the number on your ID card or through our web address to learn how to name a representative.

Enrollee's Information

Enrollee's name		Date of birth
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 grievances made by someone other than enrollee:
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 /7 days a week.

Type of grievance

Please choose one: ☐ Medical benefits ☐ Pharmacy benefits ☐ Other
<u>Important note - expedited decisions</u>: If you would like to file an expedited grievance, please select one of the following options: ☐ Check here if you are dissatisfied with our decision and want a 24 hour review of our refusal to provide you with a fast coverage determination (pharmacy benefit), organization determination (medical benefit), redetermination, or appeal review. ☐ Check here if you are dissatisfied with our decision and want a 24 hour review of our taking a 14-day extension to review your grievance, organization determination, or appeal.

Please describe your grievance. Attach any additional information about your grievance.

Signature of person filing the grievance (the enrollee or the enrollee's representative)	**Date**