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

Because Aetna (or one of our delegates) denied your request for payment for 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:
Aetna Medicare Part C Appeals & Grievances
PO Box 14067
Lexington, KY 40512

Fax Number:
1-724-741-4953

You may also ask us for an appeal through our website at **www.aetnamedicare.com**.

Who may make a request: If you want another individual (such as a family member, your doctor 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., local time, 7 days a week** 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 appeal requests made by someone other than enrollee:
If you want someone else (such as a family member, your doctor or friend) to file an appeal for you, that person must be your representative. That person may already be your representative if you've filed paperwork with your state, such as Power of Attorney papers. Attach 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.

Claim Details

Provider Name		Date service was rendered
Provider Address		
City	State	ZIP Code
Phone ( )	Amount being appealed	

Please explain your reasons for appealing.

Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your doctor and relevant medical records. You may want to refer to the explanation we provided in your denial.

Signature of person requesting the appeal (the enrollee, or the enrollee's doctor or representative)	**Date**