aetna®

Practitioner and Provider Complaint and Appeal Request

NOTE: Completion of this form is mandatory. To obtain a review submit this form as well as information that will support your appeal, which may include medical records, office notes, discharge summaries, lab records and/or member history (this is not an all-inclusive list) to the address listed on your Explanation of Benefits (EOB) or other correspondence received from Aetna.

Please provide the following information.
(This information may be found on the front of the member's ID card.)

Today's Date	Member's ID Number	Plan Type ☐ Medical ☐ Dental	Member's Group Number *(Optional)*

Member's First Name	Member's Last Name	Member's Birthdate *(MM/DD/YYYY)*

Provider Name	TIN/NPI	Provider Group *(if applicable)*
Contact Name and Title		
Contact Address *(Where appeal/complaint resolution should be sent)*		

Contact Phone	Contact Fax	Contact Email Address

To help Aetna review and respond to your request, please provide the following information.
(This information may be found on correspondence from Aetna.)
You may use this form to appeal multiple dates of service for the same member.

Claim ID Number (s)	Reference Number/Authorization Number	Service Date(s)

Initial Denial Notification Date(s)	Reconsideration Denial Notification Date(s)
CPT/CDT/HCPC/Service Being Disputed	
Explanation of Your Request *(Please use additional pages if necessary.)*	

Note: If you are acting on the member's behalf and have a signed authorization from the member or you are appealing a denial and the services have yet to be rendered, use the member complaint and appeal form and indicate you are acting on the member's behalf.

You may mail your request to:

Aetna-Provider Resolution Team
PO Box 14597
Lexington, KY 40512

Or use our National Fax Number: 859-455-8650