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 a medical item or service or a Medicare Part B prescription drug, you have the right to ask us for an appeal of our decision. You have 65 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 Appeals
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**. Expedited appeal requests can be made by phone at **1-888-267-2637 (TTY: 711)**.

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 **1-888-267-2637, (TTY 711), 8 AM to 9 PM, Monday through Sunday** to learn how to name a representative.

Enrollee's Information

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	ZIP Code
Primary Phone ( )	Enrollee's Plan ID Number	
Cell Phone ( )	Alternate phone ( )	

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 ( )	Fax Number ( )	
Cell Phone ( )	Alternate Phone ( ) Ext	

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 standard decision on a medical item or service or 7 calendar days for a standard decision on a Medicare Part B prescription drug could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your doctor indicates that waiting 30 calendar days for a medical item or service or 7 calendar days for a Medicare Part B prescription drug could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your doctor's support for an expedited appeal, we will decide if your case requires a fast decision.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS. If you have a supporting statement from your doctor, attach it to this request.**

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**