Member Complaint and Appeal Form

NOTE: Completion of this form is voluntary. To obtain a review, you or your authorized representative may also call our Member Services Department using the telephone number displayed on the member ID card or submit a request in writing to the address listed at the end of your Explanation of Benefits (EOB) or other correspondence received from Aetna.

Please provide the following information for the primary Insured/Member.
(This information may be found on the front of your 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)*
Member's E-mail Address		

Please provide the following information for the person you are submitting the request for.

First Name	Last Name	Birthdate *(MM/DD/YYYY)*

Relationship to person requesting the appeal:

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Note: If your selection is spouse, child (18 years of age or older) or other, please complete and include the attached Authorized Representative Form with your request.

Please advise if the appeal is related to:

☐ Pre-Service ☐ Post Service

To help Aetna review and respond to your request, please provide the following information.
(This information may be found on correspondence from Aetna.)

Claim ID Number (If Post Service selected above.)	Reference Number (If Pre-Service selected above.)	Service Date (If Post Service insert date of services, if Pre-Service insert date of denial.)
Explanation of Your Request *(Please use additional pages if necessary.)*		
Member's Signature		

Note: When submitting this form with your request please include:
- Bills and/or correspondence for these services.
- Any other helpful information.

You may mail your request to:

Aetna
PO Box 14463
Lexington, KY 40512

Or use our National Fax Number: 859-425-3379CRTM