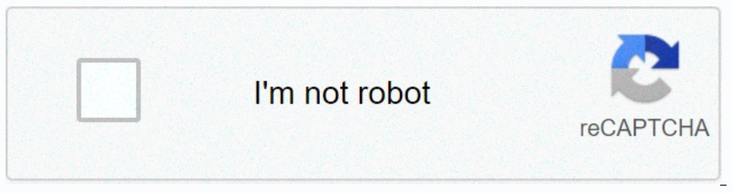

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Aetna medical provider appeal forms

A member may file a complaint when they are dissatisfied with the quality of care or service they received from one of their providers or from Aetna Better Health® California. They can make an appeal if they want to change or review a decision made about coverage. A member or his or her designated representative may file a complaint or appeal in writing or over the phone. The member must appoint his representative in writing. A representative can be a family member, friend, guardian, attorney, or other provider. Members and their representatives may also request an independent medical review (IMR) or fair medi-Cal state hearing. If a provider represents a member, the request follows members' grievance and appeals processes and deadlines. When we are asked, we help our members complete grievance and appeals forms and take other procedural action. Member Complaint and Appeals Processes Both in-network and out-of-network providers may file a formal complaint with us for things like: Policy Procedures Administrative Functions Billing and payment disputes Lost or incomplete claim forms or inappropriate or unprofited electronic references initiated by the provider Vendor's payment disputes do not include disputes related to medical need. You may also be asked to submit a dispute form (PDF) with any appropriate supporting documentation. If the complaint is about re-filing or reconsidering the complaint, we may refer the dispute to the Complaints Investigation Department (ICRC). We will then notify you of dispute resolution by phone, email, fax or writing. If the complaint needs investigation or input from another department, the Appeals and Complaints Manager will send the information to the affected department. They will coordinate with that department to investigate each complaint using applicable legal, regulatory and contractual provisions. You may file an appeal within 180 days of receipt of a Notice of Action. The Appeals and Complaints Manager will send a letter of recognition within five business days. The letter will summarize the appeal and include instructions on how to: Review the appeal within the time limit specified in the letter of recognition Withdraw an appeal at any time until the review of the Appeals Committee The Appeals and Complaints Manager will submit the appeal, along with the entire investigation, to the Appeal Committee for its decision. The Appeals Committee shall include a supplier with the same or similar specialty. They will consider the additional information and issue an appeal decision. You can file a complaint or appeal: You can file a complaint or appeal online log in to our Provider Portal: Providers may file a complaint or inquire about the appeal process by calling the Provider Services department at 1-855-772-9076 (TTY: 711). You can file a complaint or appeal by filling out a dispute form (PDF) and sending it to: Aetna Better Health of California Provider Services 10260 10260 Dr. San Diego, CA 92131 You can file a complaint or appeal by filling out a dispute form (PDF) and fax it to us at 1-844-886-8349. Any healthcare professional who provides health care services to Banner Aetna members can use the dispute process. In terms of our dispute process: Practitioners are individuals or groups that are authorized or otherwise authorized by the state in which they provide health care services to perform such services. Examples include doctors, podiatrists, and independent professionals. The organization's providers are institutional providers and health care providers. Examples include hospitals, skilled nursing centers, independent providers of durable medical equipment, and behavioral health organizations, such as mental health or residential treatment centers. What is a dispute? A dispute is a disagreement regarding a usage review or claim decision. What is the procedure for challenging a complaint decision? You can contact us by phone (for reconsiderations) or by mail within 180 days of the decision. State regulations or your provider's contract may allow for longer. To facilitate the handling of a problem: Indicate the reasons why you disagree with our decision Have the denial letter or explanation of benefits (EOB) statement and the original claim available for reference Provide appropriate documentation to support your payment dispute (i.e., a medicare carrier remittance tip, medical records, office notes, etc.). If the application does not qualify for a reconsideration as defined below, the application must be submitted in writing using the Aetna Provider Complaint and Appeal Form. What number should I call to challenge a claim decision? Call us at the number at 100 on the member's ID card. Where should I send a claim dispute if I mail? Refer to the quick reference guide or refer to the denial letter or explanation of benefits (EOB) statement for management. What is a reconsideration? A reconsideration is a formal review of a prior claim refund or coding decision, or a claim that requires reprocessing when the denial is not based on medical need or when non-hospital services are denied for not receiving prior authorization. Can I submit a reconsideration online? If so, how? Submit online through the EOB Claims Search tool. Log in to the secure provider's website through NaviNet® to access this tool. What is an appeal? An appeal is a written request from an organization's professional/provider Change: An Adverse Reconsideration Decision An adverse initial decision based on medical need or experimental coverage/research criteria An adverse decision to review initial use A refusal for non-hospital hospital services that were denied for not receiving prior approval claims decisions are decisions made during the claims award process. For example, decisions related to the vendor contract, our claims payment policies, or the processing error. Review of utilization are decisions made during precertification, simultaneous or retrospective review processes for services that require precertification. For such matters, the appeal process of the professional and provider of the organization only applies to appeals received after the services provided. The appeal process of members applies to appeals related to pre-service decisions or concurrent medical need. How long do I have to file a dispute? Refer to the quick reference guide for deadlines for filing a reconsideration or appeal. What is the deadline for responding to a dispute? Please refer to the quick reference guide for our deadlines for responding to reconsideration or appeal. Can all professionals and providers in your organization file Level 1 and Level 2 appeals? lol According to our policies, we only allow one level of appeal from the provider. What can I do if I am challenging an urgent matter? You can request an expedited appeal. Accelerated appeals are available when precertification of urgent or ongoing services has been denied and a delay in decision-making could seriously endanger the member's life or health or jeopardize the member's ability to regain maximum function. We will resolve expedited appeals within 36 hours of receipt of a two-tier or 72-hour appeals process for a one-level appeal process or within state-imposed guidelines. Please note that the member appeals process applies to expedited appeals. Post-service appeals are not eligible for accelerated handling. See the Member Health Plan Benefits FAQ for more details. Is there a charge to use Banner? Aetna's dispute process? lol There is no charge for using the Banner. Aetna dispute process. What if my state has regulations that differ from Banner? The Aetna process? State law replaces our dispute and appeals process when they apply to the member's plan. We follow all state laws and regulations. State mandates requiring different time periods shall take precedence, except as noted above. What is a member's authorized representative? A member may designate a professional or provider of the organization as an authorized representative to file an appeal on their behalf for claims involving pre-service, urgent care, or urgent simultaneous review for hospitalized patients. The organization's professional or provider must be the member's primary physician or a health care professional with knowledge of the member's medical condition. The appeal process of members applies to pre-service appeals. Is documentation required if I am filing an appeal on behalf of the member (acting as the member's authorized representative) for a post-service appeal? Yes, submit a document signed and dated by the member that specifically authorizes you to appeal on behalf of the member for the services in question. Related Links: Definitions The following definitions apply in an insurance dispute: Practitioners:A person who is licensed or otherwise authorized by the State to provide health care services. Medical. include doctors, podiatrists and independent nursing professionals. Organization providers: Institutional providers and health care providers, including behavioral health care organizations. Examples of organizational providers include, but are not limited to: hospitals, nursing homes; specialized nursing centers (SNNs), home care agencies, standing surgical centers, birth centers, urgent care centers, pain management centers, ambulance services, pharmacy, hospice, infusion centers, blood banks, diagnostic testing centers, diabetic treatment centers, residential treatment centers, MRI centers, independent providers of durable medical equipment, orthopedic facilities, cancer treatment centers, optical facilities and sleep diagnostic centers. Behavioral health organizations include, but are not limited to, mental health and chemical dependence hospitals, residential treatment facilities, partial hospital programs, intensive outpatient programs, and clinics. Behavioral health organizations can be independent or hospital-based. In addition, in the networks where the Medicare product is offered, the organization's providers must include: laboratories, comprehensive outpatient rehabilitation centers, outpatient physical therapy and speech pathology providers, and end-stage kidney disease service providers. Dispute: A disagreement regarding a decision to review the use or claim. Reconsideration: A formal review of an earlier claim payment decision as a result of a provider/practitioner investigation of the organization. If the problem of an organization provider/practitioner is eligible for reconsideration, it occurs before the appeal process. Examples include, but are not limited to: Vendor Contract Issues Claims Payment Policies Processing Error Detection Of Level 1 Appeal: An oral or written request from a professional/supplier to change: An adverse reconsideration decision An adverse claim decision based on medical need or experimental/research coverage criteria An initial precertification decision/patient management review Professionals and suppliers may request Level 1 appeals. After the first level of appeal, Aetna's internal appeal process for the organization's vendors is exhausted. Claims Issues: Issues relate to all decisions made during the claims award process, including those that result in overpayment (e.g. related to vendor contract, our claims payment policies, processing error, etc.). Review of the issues related to decisions made during precertification, simultaneous or retrospective review processes for services requiring precertification. For such matters, the appeal process of the organization's professional/provider only applies to appeals received after the services provided. The appeal process of members applies to appeals related to pre-service decisions or concurrent medical need. Level 2 Appeal: An oral or written request from a a Level 1 appeal decision. The dispute process The DisputeA professional or the organization provider may file a dispute in one of three ways: Write to the PO Box in the Explanation of Benefits (EOB) statement, denial letter, or over-payment letter related to the issue being disputed. Call our Provider Service Center at:-- 1-800-624-0756 for HMO-based benefit plans and WA Primary Choice plans-- 1-888-632-3862 for compensation information and PPO-based benefit plans Send online through the EOB Claims Search Tool – log in to the secure provider's website through NaviNet®to access this tool. You have 180 days from the date of the initial decision to file a dispute. However, you may have more time if state regulations or your organizational provider contract allow for more time. To facilitate the management of a problem, you should: Indicate the reasons why you do not agree with our decision. Have the denial letter, EOB statement or overpayment letter and the original claim available for reference. Provide appropriate documentation to support your payment dispute (for example, a Medicare carrier's remittance tip; medical records; office notes, etc.). Claims payment disputes related to reimbursement or coding are subject to our reconsideration process. Initial adverse claims decisions based on medical needs or experimental or research coverage criteria are handled as Level 1 appeals and are reviewed by physicians. Utilization review disputes are handled

as Level 1 appeals and are reviewed by physicians as well. Reconsideration If you wish to challenge a claim payment decision, please contact us for reconsideration of the decision. This is the first step in challenging a claim payment decision. A representative of the provider service center will investigate the handling of the claim in question. We will generally resolve claims payment issues related to the contract request within three to five business days. If the decision is in your favor, we will recalculate and reprocess the claim for any service affected by the decision. It may be necessary to forward claims payment issues involving refund or coding of revisions to a specialized unit for investigation and resolution. We will issue a response within 30 business days if no additional information is required, or within 30 business days of receiving the specialized unit. If the decision is in your favor, we will recalculate and reprocess the claim for any affected by the decision. After reconsideration, if the decision is not in your favor, you can initiate a Level 1 appeal. We will provide instructions on how and when to file an appeal when we issue the reconsideration decision. Appeal Case Level 1You can request a Level 1 appeal, either verbally or in writing, if you are not satisfied with: The reconsideration decision (for claim disputes) An initial claim decision based on medical need or experimental coverage/research criteria An initial precertification/patient management decision We will notify you of our Level 1 decision in writing within 30 business days of receipt of the appeal, unless we need additional information. If we need additional information, we will send the Level 1 appeal decision within 30 business days of receipt of the requested additional information. If the Level 1 appeal decision is in your favor, we will recalculate and reprocess the claim for any services affected by the decision. If the Level 1 appeal decision confirms our original position, we will send you a written response. For professionals, the notice will include information about their right to request a review of the Adverse Determination as a Level 2 appeal. For suppliers in your organization, the notice will include our final determination. Level 2 Appeal If professionals are dissatisfied with the Level 1 appeal decision, they can apply for a Level 2 appeal, either verbally or in writing, within 60 calendar days from the date of the Level 1 appeal decision. Organization providers are not eligible for a Level 2 appeal, except as required by state regulations. For appeals of a review of use, medical need, or experimental/research coverage criteria, a reviewer not associated with the Level 1 appeal will examine the Level 2 appeal. We will notify you of our Level 2 appeal decision within 30 business days of receipt of the appeal, unless we need additional information. If we need additional information, we will send the Level 2 appeal decision within 30 business days of receipt of the requested additional information. If the Level 2 appeal decision is in your favor, we will recalculate and reprocess the claim for any services affected by the decision. If the Level 2 appeal decision confirms our original position, we will send you a final resolution letter. State laws and regulationsTo the extent that our policy varies from the applicable laws or regulations of an individual state, state regulation requirements apply and supersede our policy. State law does not replace our appeals policy related to Aetna Medicare plans. State laws do not apply to Medicare plans. Aetna's law department makes the final determination when there are any questions as to the applicability of a law. QuestionsSo you have questions about our appeal process, please contact our provider service center: 1-800-624-0756 for HMO-based benefit plans and WA Primary Choice 1-888-632-3862 plans for PPO and PPO-based benefit plans