



# 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 <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Member's Group Number (Optional)
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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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		
<b>Note:</b> 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: <input type="checkbox"/> Pre-Service <input type="checkbox"/> 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**



# Authorized Representative Request

FAX Number
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Member Name	Aetna ID Number
Provider of Service	
Name and Dates of Service or Proposed Service	

I, \_\_\_\_\_, do hereby name  
*Print the name of the member who is receiving the service or supply*

\_\_\_\_\_  
*Print the name of the person who is being authorized to act on the member's behalf*

to act as my authorized representative in requesting *(check one)*

a complaint or  an appeal from Aetna regarding the above-noted service or proposed service.

**IMPORTANT: Your signature below means that you understand and agree to the following:**

- In conjunction with this *(check one)*  complaint or  appeal, Aetna may disclose Protected Health Information ("PHI") to the above-named authorized representative ("Representative").
- **The PHI disclosed pursuant to this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, HIV/AIDS, and/or genetic marker information.**
- Information disclosed pursuant to this authorization may be redisclosed by the Representative and may no longer be protected by federal or state privacy regulations.
- If you would like to pursue *(check one)*  a complaint or  an appeal, at the Representative's request, but do **not** want the Representative to receive any PHI or other information related to the *(check one)*  complaint or  appeal, including the *(check one)*  complaint or  appeal, decision, you may indicate that choice by checking the box on the signature line below.
- Your ability to enroll in an Aetna plan, and your eligibility for benefits and payment for services, will not be affected if you do not sign this form. However, without your signature, we cannot process the *(check one)*  complaint or  appeal, initiated by the Representative.
- This authorization is only valid for the duration of the *(check one)*  complaint or  appeal. If you sign this form, you may revoke the authorization at any time by notifying Aetna in writing at the address above. Revoking this authorization will not have any effect on actions that Aetna took in reliance on the authorization before we received the notification.

Please accept this *(check one)*  complaint or  appeal, from my representative on my behalf; however, forward all information related to this *(check one)*  complaint or  appeal, including the *(check one)*  complaint or  appeal decision and any request you may have for additional information, to my attention only.

Signature	Date
Print Name	
If person signing this Authorization is not the Member, describe relationship to the Member (i.e. Parent, Legal Representative)	

Legal Representatives signing this authorization on behalf of a Member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority.

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.*

English	To access language services at no cost to you, call the number on your ID card.
Albanian	Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.
Amharic	የጽንድ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎች ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավիճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հերախոսահամարով
Bantu-Kirundi	Kugira uronke serivisi z'indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe
Bengali	আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন।
Burmese	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပါတ်အား ခေါ်ဆိုပါ။
Catalan	Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d'identificació.
Cebuano	Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Cherokee	ᄆᄃᄆᄃ ᄇᄃᄆᄆᄆ ᄆᄆᄆᄆᄆ ᄆ ᄆᄆᄆᄆ ᄆᄆᄆᄆᄆᄆ ᄆᄆ, ᄆᄆᄆᄆᄆᄆ ᄆᄆᄆ ᄆᄆᄆᄆ ᄆᄆᄆᄆᄆᄆ ᄆᄆᄆᄆᄆᄆ ᄆᄆᄆᄆᄆᄆ ᄆᄆᄆᄆᄆᄆ.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Choctaw	Anumpa tosholi i toksvli ya peh pilla ho ish i payahinla kvt chi holisso kallo iskitini holhtena takanli ma i payah
Chuukese	Ren omw kopwe angei aninisin eman chon awewei (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID
Cushitic-Oromo	Tajaajiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
Dutch	Voor gratis taaldiensten, bel het nummer op uw ziekteverzekeringskaart.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કોલ કરવો.
Hawaiian	No ka wala'au 'ana me ka lawelawe 'olelo e kahea aku i ka helu kelepona ma kâu kâleka ID. Kâki 'ole 'ia kêia kōkua nei.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।

Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obula, kpọọ nọmba nọ na kaadi njirimara gi
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢပူၤတၢ်မၤကိၣ်တၢ်မၤစၢၣ်အတၢ်ဖံးတၢ်မၤတဖၣ် လၢပူၤတၢ်အိၣ်ဒီးအပူၤလၢပူၤနကတၢ်ဟ့ၣ်အိၣ်အိၣ်ကိးဘၣ်လိတဲဝဲနီၣ်တၢ်လၢပူၤအိၣ်လၢပူၤနခိၣ်ဂီၤ ၈ (၅၅) အလံၤတၢ်ကၢၤၤ
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەستگیراگەشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارە ی سەر نای دی (ID) کارتێ خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທລະສັບໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डवरील क्रमांकावर फोन करा.
Marshallese	Nan bōk jipañ kōn kajin ilo an ejjelok wōṇean n̄an kwe, kwōn kallok nōmba eo ilo kaat in ID eo aṃ.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលគេគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo búáh ílínígóó naaltsoos bee atah níljigo nanitinígíí bee néého'dólzínígíí béesh bee hane'í biká'ígíí áají' hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të koor yin ran de wëer de thokic ke cîn wëu kor keek tēnɔŋ yin. Ke yin cɔl ran ye koc kuony në namba de abac tō në ID kard duŋn de tīt de nyin de panakim köu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫੋਨ ਕਰੋ।

