Your Member Number: _____
Your Name: _____

APPEAL OF HEALTH CLAIM OR PRECERTIFICATION DENIAL BY AETNA

This form is for active employees (not retirees) of the Alaska Court System and their dependents who wish to appeal health claim or precertification denials by Aetna.

WHAT LEVEL APPEAL IS THIS?

[For more information about appealing your claims, call DRB at 1-800-821-2251; or review the health plan at http://doa.alaska.gov/drb/alaskacare/employee/publications/booklet.html; or email the Healthcare Advocates at healthcareadvocates@akcourts.us. If you are not satisfied with the administrative appeal decisions, you may appeal to Superior Court. See appeal form packets HCA-100, HCA-200, HCA-300, and HCA-400.]

☐ **Level 1 Appeal to Aetna** ☐ **Check this box if this is an urgent appeal***

*Check this box if this is your first appeal of a claim denied in full or in part. Level 1 appeals go to Aetna and must be **received** by Aetna within 180 calendar days of the Explanation of Benefits (EOB) "statement date" or precertification denial letter. You may use this online calculator to calculate the due date.*

☐ **Level 2 Appeal to Aetna** ☐ **Check this box if this is an urgent appeal***

*Check this box if **all** of these statements are true:*

a. *You are not satisfied with the level 1 appeal decision by Aetna; and*
b. *Aetna's level 1 decision was based on something different than Aetna's "medical opinion" (for example, they say your doctor's charges are more than the "recognized charge," or that the service you received is not covered by the plan, or that they need more records from your doctor); and*
c. *You want to appeal to level 2.*

*Level 2 appeals go to Aetna and must be **received** by Aetna within 180 calendar days of the date of the Level 1 decision. You may use this online calculator to calculate the due date.*

☐ **Request for External Review to Aetna** ☐ **Check this box if this is an urgent appeal***

*Check this box if **all** of these statements are true:*

a. *You are not satisfied with the level 1 appeal decision by Aetna; and*
b. *Aetna's level 1 decision was based on Aetna's "medical opinion" or Aetna's level 1 denial letter talks about "medical necessity" (for example, they say your procedure was not medically necessary, or it was experimental or investigational, or something else involving Aetna's medical or clinical decision); and*
c. *You want to request review by an independent external review company.*

Requests for external review must be submitted to Aetna no later than 4 months after you receive the level 1 denial letter. Aetna is supposed to send a copy of their form for requesting these but they don't always do that. If you do not receive a form from Aetna, use this form or form HCA-205 instead, or email the Healthcare Advocates.

☐ **Level 3 Appeal to DRB *(new for 2018)*** ☐ **Check this box if this is an urgent appeal***

*Check this box if **all** of these statements are true:*

a. *You are appealing denial of services or pre-service request provided on or after January 1, 2018; and*
b. *You are not satisfied with the external review or the level 2 appeal decision by Aetna; and*
c. *You want to appeal to level 3.*

Level 3 only applies to services received after 2017. For services received before 2018, skip level 3 and go directly to level 4 (appeal to superior court). Level 3 appeals go to the Division of Retirement & Benefits (DRB) and must be received by the DRB within 60 calendar days of the date of the external review or level 2 decision. You may use this online calculator to calculate the due date.

Level 4 Appeal to Superior Court

If you did not succeed at each of the levels below, then you may appeal to the superior court using packet HCA-400.

* **Request an urgent appeal if you believe that a delay in the appeal process could harm health or threaten life.**

Your Member Number: _____
Your Name: _____

HOW AND WHERE TO SUBMIT THIS APPEAL

I am sending my appeal today by mail and/or fax as noted below.

For Level 1 and Level 2 Appeals to Aetna:

☐ **Mail**, with delivery confirmation to:
Aetna
Attn: AlaskaCare Member Appeal
P.O. Box 14463
Lexington, KY 40512

☐ **Fax** to (859) 425-3379
(print and retain fax confirmation page)

For Requests for External Review to Aetna:

☐ **Mail**, with delivery confirmation to:
Aetna
Attn: National External Review Unit
2000 River Edge Parkway, Suite 300
Atlanta, GA 30328

☐ **Fax** to (860) 975-1526
(print and retain fax confirmation page)

For Level 3 Appeals to DRB:

☐ **Mail**, with delivery confirmation to:
Division of Retirement & Benefits
Attn: AlaskaCare Member Appeal
P.O. Box 110203
Juneau, AK 99811

☐ **Fax** to (907) 465-2805
(print and retain fax confirmation page)

For Level 4 Appeals to the Superior Court:

File your L4 appeal at the Superior Court location nearest you. Follow instructions in the HCA-400 packet. You will also need to serve a copy on: the DRB and AK Dept. of Law

WHO IS THIS APPEAL ABOUT?

My member ID # on my Aetna card is _____ My date of birth is _____
I am appealing the denial of precertification or health claim(s) regarding:

☐ myself. My name is _____
☐ my spouse (name and date of birth) _____
☐ my child (name and date of birth) _____
☐ other (name and date of birth) _____

[Continued on next page]

Your Member Number: _____
Your Name: _____

WHAT CLAIMS ARE BEING APPEALED?

*[**Instructions**: Whenever a doctor sends a bill to Aetna for payment, Aetna creates an "explanation of benefits" (EOB) statement. You can find EOBs at https://www.Aetna.com/ after logging in. Every EOB has a **statement date** in the top right corner of the 1st page; and every claim on the EOB has a **claim ID** number. Every letter from Aetna denying precertification has a **case number**. For more information, email HealthcareAdvocates@akcourts.us.]*

I am appealing the full or partial denial of the following precertification or health claims:

1. Claim or case number _____
   Statement date _____
   Date of service _____
   Provider _____

2. Claim or case number _____
   Statement date _____
   Date of service _____
   Provider _____

3. Claim or case number _____
   Statement date _____
   Date of service _____
   Provider _____

4. Claim or case number _____
   Statement date _____
   Date of service _____
   Provider _____

WHAT ELSE IS INCLUDED WITH THIS APPEAL?

I am submitting more information and documents with this appeal as follows:

- ☐ correspondence
- ☐ copy of medical records
- ☐ copy or copies of EOB's (explanation of benefits statements)
- ☐ copy of prior level appeal denial letter
- ☐ other (describe)

_____
_____
_____

- ☒ By referring to it here, I incorporate all information my provider and I submitted before; this filled-out form; the *Insurance Information Booklet* and all addenda and clarifications in effect on the relevant dates of service; the related Optum Fee Analyzer reports; and any enclosed documents. I also incorporate all recordings related to my appeal and my claims, and ask you to preserve the recordings and all related information until further notice. I also request access to copies of all documents, records, data, and other information about my claims whether or not used in making the decision, and the names of any clinical reviewers if applicable.

☐ I spoke with Aetna about this claim or claims as follows:

Date	Call Reference No.	Representative's Name/ID
_____	_____	_____
_____	_____	_____

Your Member Number: _____
Your Name: _____

THE FACTS THAT SUPPORT THIS APPEAL

I think the denial of my claims or precertification requests is unfair or improper because:

Your Member Number: _____
Your Name: _____

DATA AND DOCUMENTS REQUESTED AS PART OF THIS APPEAL

A. **Recognized charge.** This paragraph applies if my claim or claims were denied in whole or part as above the "recognized charge." I believe that the database used for setting the recognized charge is inconsistent with any usual, customary, reasonable, or prevailing rate in the geographic area where the services were performed. I believe the plan is relying on data from a database known to be incomplete, inaccurate, and indefensible. So that I may investigate this, I request the following information as part of my appeal: (1) For each month in the past 36 months, how many actual claims were submitted by Alaska providers on behalf of active and retired AlaskaCare plan members for each of the same CPTs denied in whole or part as above the recognized charge in my claim? And of these actual claims submitted, how many were denied in whole or part as above the recognized charge? (2) Which FairHealth update (May or November, and of what year) was used to process the claims I am appealing? (3) Was "derived data" used to determine the recognized charge for my claims? If so, for each CPT, how many frequencies were in the database on the date my claims were processed and what were the actual provider charge dates of each of those frequencies? (4) Provide me with a copy of all correspondence between any employee of the Alaska Department of Administration and any employee of Aetna about any of the following: FairHealth, any rate-setting database other than FairHealth, and Aetna's reimbursement policies and practices regarding the recognized charge or similar rate-setting tool or process. (5) Provide a copy of the contract or letter of agreement between Alaska and Aetna on the dates of service associated with my claims. (6) Identify the Medicare reimbursement rate in effect on the dates of service for the CPTs at issue in my claim. (7) Identify and provide a copy of every other document or source of information other than the FairHealth database that was used to process my claims.

B. **Proprietary guidelines or clinical policy bulletins.** This paragraph applies if my claim or claims were denied because of information in proprietary documents or guidelines (such as the MCG Guidelines) or an Aetna clinical policy bulletin. Please follow all necessary protocols and promptly release the documents and guidelines to me because they are being used to my detriment.

C. **Medical records.** This paragraph applies if my medical records were overlooked, ignored, or disregarded by Aetna or its external review organization in making the adverse benefit determination referenced in this appeal. Provide a copy of my medical records (1) in Aetna's possession or control whether or not used to process my claim, and (2) actually reviewed or used by Aetna's system, external review organization, or employee to process my claim. In addition, if Aetna's system processed my claim, I ask that this appeal and my future claims be processed by a human instead.

D. **Other information requested:**

_____
_____
_____
_____

DATE AND SIGN THIS APPEAL

Today's Date _____
Your Name _____ Your Telephone _____
Your Mailing Address _____
Your Signature _____