# Aetna Med D - SilverScript - Premium Billing Escalation Form - Senior Reps and Supervisors ONLY

**Before completing the escalation form:**

* Access **PeopleSafe** and thoroughly research the beneficiary’s account **prior** **notes** and RM Tasks; ensure the beneficiary’s concern has not already been resolved or is not in process.
* Educate the beneficiary on the process including TAT expectation; for example, SSA could take 1 or more months to begin & beneficiary must pay premium prior to SSA deductions starting.
* Ensure beneficiary’s contact number and address is current (Check **BOTH** the **Participant Inquiry** & **Medicare D Inquiry** tabs in **PeopleSafe**).
* Advise the beneficiary that a resolution could take up to **7** business days.

**Notes:**

* This form is **NOT** for beneficiaries with an existing CTM/Grievance on the same issue.
  + Review each account/notes/system to locate an existing CTM/Grievance.
  + Once a CTM/grievance is filed this issue is now handled by the CTM/Grievance team.
* Review account notes in the Participant Inquiry tab and Med D comments to determine the issue level.

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| --- | --- | --- | --- | --- | --- |
| **Indicate Issue Level:**  Choose Immediate or Urgent:  Immediate- Beneficiary advising they will contact CMS regarding Premium Billing issue/ Lack of medication due to Premium Billing Issue  Urgent- Member has loss of coverage but no immediate need for medication | | | | | |
| **Date of call:** | | **Has the beneficiary called numerous times about this issue:** | | | |
| **Beneficiary Name:** | | | | | |
| **Subscriber ID:** | | | **MBI/HICN:** | | **Plan Name:** |
| **List reason (s) related to beneficiary’s concern:**  Examples: Credit Card/RCD payment, EFT/eCheck payment, Dunning, Good Cause, LEP, SSA, Invoice Request, Payment plan, Payment research, Refund, SPAP, Switch to Direct Bill, Uncashed refund checks | | | | | |
| **Indicate how beneficiary contacted plan:**  **List reference numbers for any RM Tasks (Customer Care) or-EMA (Letter correspondence) etc.** | | | | | |
| **Describe the beneficiary’s concern:** | | | | | |
| **Has the beneficiary requested and/or spoke with Supervisor within last 30 days regarding this issue:** | | | | | |
| Did the beneficiary request a callback? | Was the beneficiary educated on the resolution time?  **(Note: Beneficiary must be educated on Resolution Times)** | | | Did the beneficiary request a callback?    Best time to contact beneficiary: | |

**Additional Important Notes:**

**Do not** indicate URGENT in the email subject line; all complaints received are urgent.

**Do** **not** update the subject line once sent.

**Indicate** in the body of the email if it is a second request. RM Tasks should be completed for all **non-urgent** beneficiary concerns.

**Do not** email individual premium billing team members; complaints are distributed for research based on availability.

**For VOID** **requests**: Email form to: [AutoPayDistribution@CVSCaremark.com](mailto:AutoPayDistribution@CVSCaremark.com) (**Note:** Ensure the One-Time payment was made the same day in the Premium Billing Credit Card Single-Sign-On (SSO) system)

**For ALL OTHER requests**: Email form to: [PBSpecializedCare@CVSHealth.com](mailto:PBSpecializedCare@CVSHealth.com) **Email Subject Line Format:** \*SECUREMAIL\* PHI Included - Premium Billing Escalation Form Beneficiary’s Last Name, Beneficiary’s First Name Beneficiary’s ID.