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Disputes and appeals overview

Our process for disputes and appeals

Health care providers can use the Aetna dispute and appeal process if they do not agree with a claim or utilization review decision.

The process includes:

- Peer to Peer Review - Aetna offers providers an opportunity to present additional information and discuss their cases with a peer-to-peer reviewer, as part of the utilization review coverage determination process. The timing of the review is prior to an appeal and incorporates state, federal, CMS and NCQA requirements.
- Reconsiderations: Formal reviews of claims reimbursements or coding decisions, or claims that require reprocessing.
- Appeals: Requests to change a reconsideration decision, an initial utilization review decision, or an initial claim decision based on medical necessity or experimental/investigational coverage criteria.

To help us resolve the dispute, we'll need:

- A completed copy of the appropriate form
- The reasons why you disagree with our decision
- A copy of the denial letter or Explanation of Benefits letter
- The original claim
- Documents that support your position (for example, medical records and office notes)

Find dispute and appeal forms

Have dispute process questions?

Read our dispute process FAQs

Or contact our Provider Service Center (staffed 8 a.m. - 5 p.m. local time):

- **1-800-624-0756** ${tty} for HMO-based benefits plans
- **1-888-632-3862** ${tty} for indemnity and PPO-based benefits plans

Timeframes for reconsiderations and appeals

Dispute level	Doctor / provider submission timeline	Aetna response timeframe	Contacts
Reconsideration	Within 180 calendar days of the initial claim decision.	Within 45 business days of receiving the request, depending on the matter in question, and if review by a specialty unit is needed.	Submit online and check the status through your secure provider website. Write: See mailing addresses below. Call: See phone numbers above.
Appeals	Within 60 calendar days of the previous decision.*	Within 60 business days of receiving the request. If additional information is needed, within 60 calendar days of receiving that information.	Call: See phone numbers above. Write: Medicare contracted appeals use:

Dispute level	Doctor / provider submission timeline	Aetna response timeframe	Contacts
			Medicare Provider Appeals PO Box 14835 Lexington, KY 40512 Fax 860-900-7995 Medicare non contracted appeals use: Medicare Non Contracted Provider Appeals PO Box 14067 Lexington, KY 40512 Fax 724-741-4953 Non Medicare appeals use: Aetna Provider Resolution Team PO Box 14020 Lexington, KY 40512 Fax 859-455-8650
Dispute level	Reconsideration		
Doctor / provider submission timeline	Within 180 calendar days of the initial claim decision.		
Aetna response timeframe	Within 45 business days of receiving the request, depending on the matter in question, and if review by a specialty unit is needed. Submit online and check the status through your secure provider website.		
Contacts	Write: See mailing addresses below. Call: See phone numbers above.		
Dispute level	Appeals		
Doctor / provider submission timeline	Within 60 calendar days of the previous decision.*		
Aetna response timeframe	Within 60 business days of receiving the request. If additional information is needed, within 60 calendar days of receiving that information.		
Contacts	Call: See phone numbers above. Write: Medicare contracted appeals use: Medicare Provider Appeals		

PO Box 14835

Lexington, KY 40512

Fax 860-900-7995

Medicare non contracted appeals use:

Medicare Non Contracted Provider Appeals

PO Box 14067

Lexington, KY 40512

Fax 724-741-4953

Non Medicare appeals use:

Aetna Provider Resolution Team

PO Box 14020

Lexington, KY 40512

Fax 859-455-8650

*The timeframe is 180 calendar days for appeals involving utilization review issues or claims issues based on medical necessity or experimental/investigational coverage criteria.

See state exceptions to these timeframes

Mailing addresses for reconsiderations

State	Address
AL, AK, AR, AZ, CA, FL, GA, HI, ID, LA, MS, NC, NM, NV, OR, SC, UT, TN, WA	Aetna Provider Resolution Team PO Box 14079 Lexington, KY 40512-4079
CO, CT, DC, DE, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MT, NE, ND, NH, NJ, NY, OH, OK, PA, RI, SD, TX, VA, VT, WI, WV, WY	Aetna Provider Resolution Team PO Box 981106 El Paso, TX 79998-1106

State AL, AK, AR, AZ, CA, FL, GA, HI, ID, LA, MS, NC, NM, NV, OR, SC, UT, TN, WA

Address Aetna Provider Resolution Team

PO Box 14079

Lexington, KY

	40512-4079
State	CO, CT, DC, DE, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MT, NE, ND, NH, NJ, NY, OH, OK, PA, RI, SD, TX, VA, VT, WI, WV, WY
Address	Aetna Provider Resolution Team PO Box 981106 El Paso, TX 79998-1106

Log in

Use our secure provider website to access electronic transactions and valuable resources to support your organization.

Find a form

Find forms for claims, payment, billing, Medicare, pharmacy and more.

Clinical policy bulletins

View medical, dental or pharmacy clinical policy bulletins.

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Health benefits and health insurance plans contain exclusions and limitations.

See all legal notices

Also of interest:

For language services, please call the number on your member ID card and request an operator. For other language services: Español-Spanish | 中文 | Tiếng Việt | 𓂋𓏏𓈖 | Tagalog | Русский | العربية | Kreyòl | Français | Polski | Português | Italiano | Deutsch | 日本語 | فارسی | Other languages ...

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You are now being directed to the Apple.com COVID-19 Screening Tool

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Login

Please log in to your secure account to get what you need.

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You are now leaving the Aetna Medicare website.

The information you will be accessing is provided by another organization or vendor. If you do not intend to leave our site, close this message.

Continue

Get a link to download the app

Just enter your mobile number and we'll text you a link to download the Aetna Health℠ app from the App Store or on Google Play.

Message and data rates may apply*

MOBILE NUMBER Please be sure to add a 1 before your mobile number, ex: 19876543210

This search uses the five-tier version of this plan

Each main plan type has more than one subtype. Some subtypes have five tiers of coverage. Others have four tiers, three tiers or two tiers. This search will use the five-tier subtype. It will show you whether a drug is covered or not covered, but the tier information may not be the same as it is for your specific plan. Do you want to continue?

back

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Applied Behavior Analysis Medical Necessity Guide

By clicking on “I Accept”, I acknowledge and accept that:

The Applied Behavior Analysis (ABA) Medical Necessity Guide helps determine appropriate (medically necessary) levels and types of care for patients in need of evaluation and treatment for behavioral health conditions. The ABA Medical Necessity Guide does not constitute medical advice. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any matters related to their coverage or condition with their treating provider.

Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Aetna) for a particular member. The member's benefit plan determines coverage. Some plans exclude coverage for services or supplies that Aetna considers medically necessary.

Please note also that the ABA Medical Necessity Guide may be updated and are, therefore, subject to change.

Medical necessity determinations in connection with coverage decisions are made on a case-by-case basis. In the event that a member disagrees with a coverage determination, member may be eligible for the right to an internal appeal and/or an independent external appeal in accordance with applicable federal or state law.

I Accept

Aetna® is proud to be part of the CVS® family.

You are now being directed to CVS Caremark® site.

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ASAM Terms and conditions

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Licensee's use and interpretation of the American Society of Addiction Medicine’s ASAM Criteria for Addictive, Substance-Related, and Co-Occurring Conditions does not imply that the American Society of Addiction Medicine has either participated in or concurs with the disposition of a claim for benefits.

This excerpt is provided for use in connection with the review of a claim for benefits and may not be reproduced or used for any other purpose.

I accept

Precertification lists

By clicking on “I accept”, I acknowledge and accept that:

Should the following terms and conditions be acceptable to you, please indicate your agreement and acceptance by selecting the button below labeled "I Accept".

- The term precertification here means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO members.
- Applies to: Aetna Choice® POS, Aetna Choice POS II, Aetna Medicare℠ Plan (PPO), Aetna Medicare Plan (HMO), all Aetna HealthFund® products, Aetna Health Network Only℠, Aetna Health Network Option℠, Aetna Open Access® Elect Choice®, Aetna Open Access HMO, Aetna Open Access Managed Choice®, Open Access Aetna Select℠, Elect Choice, HMO, Managed Choice POS, Open Choice®, Quality Point-of-Service® (QPOS®), and Aetna Select℠ benefits plans and all products that may include the Aexcel®, Choose and Save℠, Aetna Performance Network or Savings Plus networks. Not all plans are offered in all service areas.
- All services deemed "never effective" are excluded from coverage. Aetna defines a service as "never effective" when it is not recognized according to professional standards of safety and effectiveness in the United States for diagnosis, care or treatment. Visit the secure website, available through www.aetna.com, for more information. Click on "Claims," "CPT/HCPCS Coding Tool," "Clinical Policy Code Search."
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I accept

Dental clinical policy bulletins

By clicking on “I accept”, I acknowledge and accept that:

- Aetna Dental Clinical Policy Bulletins (DCPBs) are developed to assist in administering plan benefits and do not constitute dental advice. Treating providers are solely responsible for dental advice and treatment of members. Members should discuss any Dental Clinical Policy Bulletin (DCPB) related to their coverage or condition with their treating provider.
- While the Dental Clinical Policy Bulletins (DCPBs) are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. The Dental Clinical Policy Bulletins (DCPBs) describe Aetna's current determinations of whether certain services or supplies are medically necessary, based upon a review of available clinical information. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply. Aetna's conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Aetna). Your benefits plan determines coverage. Some plans exclude coverage for services or supplies that Aetna considers medically necessary. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State or the Federal government.
- Please note also that Dental Clinical Policy Bulletins (DCPBs) are regularly updated and are therefore subject to change.
- Since Dental Clinical Policy Bulletins (DCPBs) can be highly technical and are designed to be used by our professional staff in making clinical determinations in connection with coverage decisions, members should review these Bulletins with their providers so they may fully understand our policies.
- Under certain plans, if more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that certain terms are met.

I accept

Medical clinical policy bulletins

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Should the following terms and conditions be acceptable to you, please indicate your agreement and acceptance by selecting the button below labeled "I Accept".

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- While the Clinical Policy Bulletins (CPBs) are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. The Clinical Policy Bulletins (CPBs) express Aetna's determination of whether certain services

or supplies are medically necessary, experimental and investigational, or cosmetic. Aetna has reached these conclusions based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors).
- Aetna makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in the Clinical Policy Bulletins (CPBs). The discussion, analysis, conclusions and positions reflected in the Clinical Policy Bulletins (CPBs), including any reference to a specific provider, product, process or service by name, trademark, manufacturer, constitute Aetna's opinion and are made without any intent to defame. Aetna expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information including correction of any factual error.
- CPBs include references to standard HIPAA compliant code sets to assist with search functions and to facilitate billing and payment for covered services. New and revised codes are added to the CPBs as they are updated. When billing, you must use the most appropriate code as of the effective date of the submission. Unlisted, unspecified and nonspecific codes should be avoided.
- Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Aetna) for a particular member. The member's benefit plan determines coverage. Some plans exclude coverage for services or supplies that Aetna considers medically necessary. If there is a discrepancy between a Clinical Policy Bulletin (CPB) and a member's plan of benefits, the benefits plan will govern.
- In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members.

See CMS's Medicare Coverage Center

- Please note also that Clinical Policy Bulletins (CPBs) are regularly updated and are therefore subject to change.
- Since Clinical Policy Bulletins (CPBs) can be highly technical and are designed to be used by our professional staff in making clinical determinations in connection with coverage decisions, members should review these Bulletins with their providers so they may fully understand our policies. Under certain circumstances, your physician may request a peer to peer review if they have a question or wish to discuss a medical necessity precertification determination made by our medical director in accordance with Aetna’s Clinical Policy Bulletin.
- While Clinical Policy Bulletins (CPBs) define Aetna's clinical policy, medical necessity determinations in connection with coverage decisions are made on a case by case basis. In the event that a member disagrees with a coverage determination, Aetna provides its members with the right to appeal the decision. In addition, a member may have an opportunity for an independent external review of coverage denials based on medical necessity or regarding the experimental and investigational status when the service or supply in question for which the member is financially responsible is $500 or greater. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans.

See Aetna's External Review Program

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