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## Don’t have an account?

Sign up to find care, manage costs, try a health program and more. We’re with you on your journey.

Register

Already have an account? Log in

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## Medicare

Going beyond Original Medicare with medical benefits, drug coverage and added benefits and services.

Go to Aetna Medicare

## Affordable Care Act (ACA)

The quality Aetna® network of trusted local doctors plus the convenience of CVS® for individuals and families.

Go to Aetna CVS Health

## Medicaid

Support and guidance for Medicaid members on their path to better health. We’re changing the way people get care.

Go to Aetna Better Health

## Other sites for you

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- Aetna Student health

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1. Individual and family insurance plans
2. Member rights and resources
3. Claims and denials

# Claim denials

## How to appeal a denial claim

If we deny a claim and you do not agree, you can ask for a review. This is called an appeal. There are two ways to do this:

- Call Member Services at the phone number on your member ID card
- To submit your request in writing you can print and mail the following form:

Member complaint and appeal form (PDF)

You may appeal on your own. You also may authorize someone to appeal for you. This is called an authorized representative.

## How long do I have to ask for an appeal

You have 180 days from when you get the notice of the denied claim, unless your plan brochure (or Summary Plan Description) gives you a longer period of time.

## What should the request include

- The group name (usually your employer or organization that sponsors your plan)
- Your name
- Your member ID number (found on your medical ID card)
- Any comments, documents, records and other information you would like us to consider. If there are documents you need for your claim, call the Member Services phone number listed on your member ID card. We will send them to you free of charge.

## How long will it be before Aetna makes a decision?

How soon we respond may vary. It depends on a state law, whether your appeal is urgent or your plan offers one or two levels of appeal.

### Plans that provide for one appeal

- If we had to approve your claim before you got care, we will decide within 30 days of getting your appeal.
- For other claims, we'll decide within 60 days.

### Plans that provide for two appeals

- If we had to approve your claim before you got care, we will decide within 15 days of getting your appeal.
- For other claims, we'll decide within 30 days.
- In either case, if you do not agree with our decision, you can ask for a second review. You have 60 days from the date that you get the appeal decision letter to let us know. You can call Member Services at the phone number listed on your member ID card, or write to us.

### Urgent care claims

We make decisions for urgent care claims more quickly. If your doctor feels that a delay will put your health, your life or your recovery at serious risk or cause you severe pain, that's an urgent care claim. You or your doctor may ask for an "expedited" appeal. Call the toll-free number on your Member ID card or the number on the claim denial letter.

- Once expedited review is requested, our clinical team reviews the request to decide if our criteria is met for urgent appeal, if it is not met the appeal then flows to our standard workflow.
- If your plan has one level of appeal, we'll tell you our decision no later than 72 hours after we get your request for review.
- If your plan has two levels of appeal, we'll tell you our decision no later than 36 hours after we get your request for review.

## What is an external review?

What if your claim is still denied after your appeals? You may be able to have a third party (independent party) review your denied claim. This is called an external review.

The Affordable Care Act (ACA) created new rules for health plans. Now health plans that are subject to the law must include an external review process.

Learn about the Aetna external review program

## In this section

- Your rights as a healthcare consumer
- Claims and coverage
- Claims, grievances, and appeals
- Commitment to quality
- Aetna member services

- Your rights as a healthcare consumer
- Claims and coverage
- Claims, grievances, and appeals

- Commitment to quality
- Aetna member services

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Health benefits and health insurance plans contain exclusions and limitations.

See all legal notices

## Also of interest:

- 
- 
- 
- 

## Contact us

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- Aetna Better Health
- Aetna CVS Health
- Aetna International
- Aetna Medicare
- Aetna Student Health

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- Company news
- Investor info

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- Find a drug
- Find insurance FAQs
- Get the Aetna Health app
- Search health care terms
- Site map

## How we protect you

- Accessibility services
- Fraud prevention
- Health care reform
- Non-discrimination notice

- Privacy center
- Website security program



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 | □□□ | 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 CVS Health site.

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## You are now being directed to the US Department of Health and Human Services site

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## You are now being directed to The Fight Is In Us site

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## Login

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

Continue

## 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

Continue

## 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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- This information is neither an offer of coverage nor medical advice. It is only a partial, general description of plan or program benefits and does not constitute a contract. In case of a conflict between your plan documents and this information, the plan documents will govern.

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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- 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, investigational, unproven, 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).

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- 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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We're working with 3Won to process your request for participation. Please select "Continue to ProVault to begin the contracting and credentialing process.

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Continue to ProVault

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Proceed to Healthcare.gov site

Continue

## Using our glossary

By choosing “I accept,” I understand that:

Our glossary lists general terms we use on our site. To get specific info about your plan’s definition of a term, or for coverage details, check your plan documents.

I accept