Aetna Medical Necessity Appeal Template

[YOUR LETTERHEAD]

[DATE]

Aetna Inc.
Attn: Appeals Department
P.O. Box 14463
Lexington, KY 40512-4463

RE: APPEAL OF MEDICAL NECESSITY DENIAL

Member Name: [MEMBER NAME]
Member ID: [MEMBER ID]
Claim Number: [CLAIM NUMBER]
Date of Service: [DOS]
CPT Code(s): [CPT CODES]
Original Denial Code: CO-50 (Lack of Medical Necessity)
Denial Date: [DENIAL DATE]

To Whom It May Concern:

This letter constitutes a formal appeal of Aetna's denial of coverage for [PROCEDURE/SERVICE] provided to the above-referenced member on [DATE]. The denial was issued citing "lack of medical necessity" under Aetna policy [POLICY NUMBER].

I. Medical Necessity Is Established

The requested service meets Aetna's definition of medical necessity as outlined in your Clinical Policy Bulletin [CPB NUMBER], which states that coverage is provided when the following criteria are met:

1. [CRITERION 1 FROM POLICY]
2. [CRITERION 2 FROM POLICY]
3. [CRITERION 3 FROM POLICY]

Our patient meets ALL of these criteria, as evidenced by the attached clinical documentation:

• [CLINICAL FINDING 1 - cite specific test results, dates, values]
• [CLINICAL FINDING 2 - cite symptoms, duration, severity]
• [CLINICAL FINDING 3 - cite failed conservative treatments with dates]

II. Conservative Treatment Was Attempted

Per Aetna's step-therapy requirements outlined in CPB [NUMBER], the member completed the following conservative measures without clinical improvement:

• [TREATMENT 1]: [DATES] - [OUTCOME]
• [TREATMENT 2]: [DATES] - [OUTCOME]
• [TREATMENT 3]: [DATES] - [OUTCOME]

Documentation of failed conservative therapy is attached (see Exhibit A: Treatment Notes [DATES]).

III. Clinical Guidelines Support Coverage

The requested service is consistent with evidence-based clinical guidelines from [NAME OF PROFESSIONAL SOCIETY], which Aetna recognizes in CPB [NUMBER]. Specifically:

• [GUIDELINE RECOMMENDATION 1]
• [GUIDELINE RECOMMENDATION 2]

Copies of the relevant guideline sections are attached (Exhibit B).

IV. Request for Reconsideration

Based on the medical necessity criteria outlined in Aetna policy [POLICY NUMBER], the clinical evidence demonstrating failed conservative treatment, and the supporting clinical guidelines, we respectfully request that Aetna:

1. Reverse the denial and approve coverage for [SERVICE]
2. Process the claim for payment at the contracted rate
3. Provide written confirmation of approval within 15 business days

If Aetna requires additional clinical information to support this appeal, please contact our office immediately at [PHONE] or [EMAIL]. We are prepared to arrange a peer-to-peer discussion with the reviewing medical director if that would expedite resolution.

Exhibits Attached:
A. Treatment notes documenting conservative therapy [DATES]
B. Clinical guideline excerpts from [PROFESSIONAL SOCIETY]
C. Diagnostic test results [DATES]
D. Aetna Clinical Policy Bulletin [CPB NUMBER] (highlighted relevant sections)

We request a response to this appeal within 30 days as required by [STATE] insurance regulations. If Aetna upholds the denial, please provide a detailed written explanation citing the specific policy language and clinical rationale.

Sincerely,

[PROVIDER NAME, CREDENTIALS]
[NPI NUMBER]
[PRACTICE NAME]
[PHONE] | [EMAIL]

cc: Member
cc: [STATE] Department of Insurance (if required)