# Aetna Better Health® of Maryland

## Provider Appeal and Complaint Form

Please complete this form when filing an appeal or grievance. Please do not use this form to submit corrected claims or resubmissions. You should complete the Provider Dispute Form.

As a reminder, appeals must be requested within ninety (90) business days from the date of retro-authorization denial or the date of an adverse determination in the provider claim dispute process.

| Appeal | Complaint /Grievance |
|---|---|
| A request by a provider to appeal actions of the health plan when the provider:<br>• Has a request for a retro-authorization of service delivery denied or not acknowledged with reasonable promptness<br>• Has a claim that has been denied or paid differently than expected and was not resolved to the provider's dissatisfaction through the provider dispute process<br><br>An appeal is the formal process for resolving provider claims disputes.<br><br>Appeals must be requested within ninety (90) business days from the date of retro-authorization denial or the date of an adverse determination in the provider claim dispute process | Any written or verbal expression of dissatisfaction by a provider, against Aetna Better Health policies, procedures or any aspect of Aetna Better Health administrative functions including complaints, about any matter other than an appeal, which is covered under the Provider Appeals policy. Possible subjects of grievances include, but are not limited to, issues regarding:<br>• Administrative issues<br>• Payment and reimbursement issues<br>• Dissatisfaction with the resolution of a dispute<br>• Aetna Better Health staff service or behavior<br>• Vendor staff service or behavior<br><br>A grievance is the formal process for resolving provider disputes not related to an appeal. |

Please complete the following:

| | |
|---|---|
| Provider Name: | |
| Provider Tax Identification Number (TIN): | |
| Provider Billing National Provider Identifier (NPI) | |
| Medicaid Provider Number: | |
| Member's Name: | |
| Member's ID Number: | |

| | |
|---|---|
| Denied Claim Number(s): | |
| Date(s) of Service: | |
| Remittance Advice Date: | |
| Billed Amount: | |
| Paid Amount: | |
| Contact Name: | |
| Contact Phone Number: | |
| Contact Address: | |

| If you are filing a complaint, please complete the below: | | | |
|---|---|---|---|
| Select the appropriate reason for your complaint from the below list: | | | |
| ☐ | Payment and reimbursement issues | ☐ | Dissatisfaction with the resolution of a dispute |
| ☐ | Vendor staff service or behavior | ☐ | Aetna Better Health staff service or behavior |
| ☐ | Other: | | |

Please include relevant claims information and any supporting documents (e.g. medical records) and mail to:

Aetna Better Health of Maryland
Attention: Appeals Department
P.O. Box 81040
5801 Postal Rd
Cleveland, OH 44181
Fax Number: **1-844-312-4257**

Once your appeal is received, an acknowledgement letter will be sent to you. If you have questions, contact us at **1-866-827-2710**.