# Aetna Better Health® of Louisiana

## Request for Appeal

If you need this in larger type or another format, call Member Services at **1-855-242-0802 (TTY: 711)**
Llame hoy mismo al **1-855-242-0802 (TTY: 711)** si usted desea recibir esta carta en español.

Because Aetna Better Health denied your request for coverage of (or payment for) an item or service, you have the right to ask us for an appeal of our decision. You have 60 days from the date of the written notice of a decision that was sent to you. To request an appeal in writing send us a letter telling us the details of what you are appealing and why or you may complete this form. Send your written request or this form by mail or fax:

**Address:**
Aetna Better Health of Louisiana
Grievance System Manager
PO Box 81139, 5801 Postal RD
Cleveland, OH 44181

**Fax Number:**
**1-860-607-7657**

You may also ask us to submit an appeal through our website at **AetnaBetterHealth.com/Louisiana**. Appeal requests can also be made by phone at **1-855-242-0802 (TTY: 711)**.

**Who may make a request:** You or another individual (such as a family member or friend) that you want to act for you can request an appeal. If the appeal comes from someone besides you, we must receive your written authorization before we can review the appeal. If you want someone to act for you they must be your representative. Contact us to learn how to name a representative.

**Member's Information**

Member's Name _____ Date of Birth _____

Member's Address _____

City _____ State _____ Zip Code _____

Phone _____ Member's Plan ID Number _____

**Complete the following ONLY if the person making this request is not the member:**

Requestor's Name _____

Requestor's relationship to member _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

**Representation documentation for grievance requests made by someone other than member (if applicable see above under *Who may make a request*):**

Attach documentation showing the authority to represent the member if it was not submitted previously. For more information on appointing a representative, contact us at **1-855-242-0802 (TTY: 711).**

**Item or service being appealed**

Description _____

_____

_____

Date of the notice of denial you received _____

Did you receive the item pending appeal? ☐ Yes ☐ No

If "Yes":

Date of service _____ Amount paid $ _____ (attach copy of receipt)

**Important note: Fast decisions, also called expedited decisions**
If you or your doctor believe that waiting 30 calendar days could seriously harm your life or health, you can ask for an expedited (fast) decision. If your doctor indicates that waiting the timeframe for a standard decision could seriously harm your life or health, we will automatically give you a fast decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking for an appeal for medical care or an item you already received.

☐ **Check this box if you are requesting an expedited appeal decision within 72 hours.**

**If you have a supporting statement from your doctor, attach it to this request.**

**Please explain your reasons for appealing.** Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your doctor and relevant medical records. You may want to refer to the explanation we provided in the denial notice.

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Signature of person requesting the appeal:

_____ Date: _____