Are you a provider not in the Aetna network? If so, here's how you can appeal a denial.

You can appeal the claim determination or decision if:

- You do not have a contract with us to participate in our Medicare Advantage plans (non-contract provider)
- You sign a completed Waiver of Liability
- You disagree with our initial claim decision
  - NOTE: If you are disputing the amount you can collect if the beneficiary were in Original Medicare pursuant to § 422.214(a)(1), you will need to follow the Aetna® payment dispute process. You'll find more information at **Aetna.com/health-care-professionals/disputes-appeals/disputes-appeals-overview.html**

The Centers for Medicare & Medicaid Services (CMS) describes the appeal process for non-contract providers in section 50.1.1-Requirements for Provider Claim Appeals (Part C Only) of the **Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf**.

The manual states:

> A non-contract provider, on his or her own behalf, may request a reconsideration for a denied claim only if the non-contract provider completes a Waiver of Liability statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal.

Use the following link to get a copy of the provider Waiver of Liability form. You must complete the entire form. Be sure to include:

- Medicare beneficiary identification number (MBIN) or enrollee plan ID
- Applicable dates of service
- Health plan name

You must also submit your request in writing, signed by the initiator. Please send your written request for an appeal to:

Aetna Medicare Part C Appeals
PO Box 14067
Lexington, KY 40512

Please provide us with all appropriate documentation to support your appeal. For example, remittance advice from a Medicare carrier. You must submit your request to Aetna Medicare no later than 65 days from the date of the denial notice.

If we find in your favor, we'll pay you at the applicable Medicare rate. If we do not find fully in your favor, per the Medicare appeal process, we'll forward your case file to MAXIMUS Federal Services, Inc. MAXIMUS is an independent review entity contracted with CMS for external reviews. They will notify you directly, in writing, of its decision. If the decision is not in your favor, they'll advise you on further appeal rights.

If you request an appeal and you did not include a Waiver of Liability form, we'll let you know. You must send us a completed and signed form before we can review your request for an appeal. If we don't get the form within 65 calendar days of our receipt of your appeal request, per the **Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf**, we'll dismiss your request for an appeal. We'll notify you of this in writing.

If you have questions about the appeal process, call us at **1-800-624-0756,** Monday to Friday, 8 AM to 5 PM ET.

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