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Aetna Medicare Advantage Plan non-contract provider payment appeal process

You have the right to appeal our payment denial by initiating the Medicare Managed Care Beneficiary Appeals Process. This process is applicable to Medicare Advantage Plans if:

- You do not have a contract with Aetna to participate in our Medicare Advantage (MA) plans (non-contract provider)
- You received zero payment for services you provided to an Aetna Medicare member enrolled in an Aetna MA HMO or PPO plan
- You sign a completed Waiver of Liability (WOL)

The Centers for Medicare and Medicaid Services (CMS) describes the appeal process available to non-contract providers ("provider-as-party") in Chapter 13 of the *Medicare Managed Care Manual.* It's titled "Non-Contract Provider Appeals."

Chapter 13 of the manual states:

> A non-contract provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which provides that the 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. It's important that you complete the entire form. You must include the:

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

For more information on HICNs, refer to Section 50.2 of Chapter 2 of the *Medicare Managed Care Manual*, titled "Medicare General Information, Eligibility, and Entitlement Manual". You can also find this manual on the CMS website at http://www.cms.gov/Manuals/IOM/list.asp.

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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 & Grievances
P.O. 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 60 days from the date of the denial notice.

We'll review your payment appeal and respond. Our response will be within 60 days from the time we receive your request for an appeal and signed provider Waiver of Liability form.

If we find in your favor, payment will be made at the applicable Medicare rate directly to you. 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 Federal Services Inc. is an independent review entity contracted with CMS for external reviews. MAXIMUS Federal Services, Inc. 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 provide us with a completed and signed form before we can review your request for an appeal. If we don't get the form within 60 calendar days of our receipt of your appeal request, per the Medicare Managed Care Manual, Chapter 13, your request for an appeal will be dismissed. You will receive written notification of the dismissal.

If you have questions regarding the appeal process, please contact our Provider Service Center at 1-800-624-0756, Monday through Friday, 8 a.m. to 5 p.m, ET.

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