

Dental Insurer Appeals Process Information Packet

Aetna Life Insurance Company

Please read this notice carefully and keep it for future reference. It contains important information about how to appeal decisions we make about your dental coverage.

Getting Information about the Dental Appeals Process

Help in Filing an Appeal: Standardized Forms and Consumer Assistance from the Department of Insurance

We must send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. To request a copy, just call the Member Services number printed on your Member ID Card.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Insurance Department (“the Department”) developed these forms to help people who want to file a dental appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department’s Consumer Assistance Office at **602-364-2499** or **1-800-325-2548** (inside Arizona but outside the Phoenix area) or via the Internet at **www.azinsurance.gov** or you may call us at **1-877-238-6200**.

How to know when you can appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us, or through your treating provider.

Decisions you can appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not “medically necessary”.
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.
7. You disagree with our decision to issue or not issue a policy to you.

Decisions you cannot appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of “usual, customary, and reasonable charges”. Where applicable, a usual, customary, and reasonable charge is a charge for a covered benefit which is determined by us to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. We may take into account factors such as the complexity, degree of skill needed, type or specialty of the provider, range of services provided by a facility, and the prevailing charge in other areas in determining the usual, customary, and reasonable charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.

5. You are dissatisfied with any rate increases you may receive under your insurance policy.
6. You believe we have violated any part of the Arizona Insurance Code.

If you disagree with a decision that cannot be appealed according to this list, you may still file a complaint with us by calling our Customer Services Department at the number printed on your Member ID Card. In addition, you may also file such complaints with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th Street, Second Floor, Phoenix, AZ 85018.

Who Can File an Appeal

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form. If you wish, you can send us a letter with the same information. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the appeals process

I. Levels of Review

We offer expedited as well as standard appeals for Arizona residents. Expedited appeals are for urgently needed services that you have not yet received. Standard appeals are for non-urgent service requests and denied claims for services already provided. Both types of appeals follow a similar process, except that we process expedited appeals much faster because of the patient's condition.

Each type of appeal has three levels, as follows:

Expedited Appeals	Standard Appeals
(For urgently needed services you have not yet received)	(For non-urgent services or denied claims)
Level One: Expedited Medical Review	Informal Reconsideration
Level Two: Expedited Appeal	Formal Appeal
Level Three: Expedited External, Independent Medical Review	External, Independent Medical Review

We make the decisions at Level One and Level Two. An outside reviewer, who is completely independent from our company, makes Level Three decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level Three. These three levels of Appeals are discussed more fully below:

Before requesting a level three, you must exhaust the internal appeal process unless:

- We waive the exhaustion requirement
- We fail to comply with the requirements of the internal appeal process except failures that are based on de minimis violations
- You request a simultaneous expedited internal and external appeal.

You may supply additional information that you would like us to consider. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting us at the number on your member identification card.

Expedited appeal process for urgently needed services not yet provided

Expedited Medical Review (Level One)

Your Request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:

- You have coverage with us;
- We denied your request for a covered service; and
- Your treating provider certifies that the time required to process your request through the Informal Reconsideration (Level One) and Formal Appeal (Level Two) appeal process (about 30 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and documentation to:

Name: Aetna Life Insurance
 Title: Company
 Address: Dental Grievances and Appeals Unit
 P.O. Box 14021, Lexington, KY 40512-4021
 Phone: 1-877-238-6200
 Fax: 859-455-8650

Our decision: We must call and inform you and your treating provider of our decision within **1 business day or 36 hours from request receipt, whichever is less.** We will then mail our decision in writing to both you and your treating provider. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision. You may simultaneously request an internal and external expedited appeal.

If we deny your request: You may immediately appeal to Level Two.

If we grant your request: We will authorize the service and the appeal process is complete.

If we refer your case to Level Three: We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

Expedited Appeal (Level Two)

Your request: If we deny your request at Level One, you may request an Expedited Appeal. After you receive our Level One denial, your treating provider *must immediately* send us a request (to the same person and address listed above under Level One) to tell us you are appealing to Level Two. To help your appeal, your provider should also send us any more information that the provider hasn't already sent us to show why you need the requested service.

Our decision: We must call and inform you and your treating provider of our decision within **1 business day or 36 hours from request receipt, whichever is less.** We will then mail our decision in writing to both you and your treating provider. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level Three.

If we grant your request: We will authorize the service and the appeal process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

Expedited External, Independent Review (Level Three)

Your request: You may Appeal to an Expedited External Independent Medical Review only after you have appealed through Level Two. You have four months after you receive an Aetna Level Two decision to send Aetna your written request for Expedited External Independent Medical Review. Your request should include any additional information to support your request for the service. Your written request for Expedited External Independent Medical Review should be sent to:

Name:	Priscilla Bugari, R.N.
Title:	Director, Aetna National External Review Unit
Address:	1100 Abernathy Rd, Suite 375, Atlanta, GA 30328
Phone:	1-877-848-5855 (Toll free)
Fax:	860-975-1526

You and your treating Provider are not responsible for the cost of any Expedited External Independent Medical Review.

Process

There are 2 types of Expedited External Independent Medical Review Appeals, depending on the issues in your case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) you or your treating Provider are asking for, are not Medically Necessary to treat your condition or do not meet criteria for appropriateness, health care setting, level of care, or effectiveness of a covered benefit. The expedited external independent reviewer is a Provider retained by an outside independent review organization (“IRO”), that is procured by the Arizona Department of Insurance, and is not connected with Aetna. The IRO Provider must be a Provider who typically manages the condition under review.

Within 1 business day of receiving your request, Aetna must:

- Mail a written acknowledgement of the request to the Director of Insurance, you and your treating Provider.
- Send the Director of Insurance: the request for review; your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna’s decision; a summary of the applicable issues including a statement of Aetna’s decision; the criteria used and clinical reasons for Aetna’s decision; and the relevant portions of Aetna’s utilization review guidelines. Aetna must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving Aetna’s information, the Director of Insurance must send all the submitted information to the external independent reviewer organization (the “IRO”).

Within 72 hours of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

Within 48 hours of receiving the IRO’s decision, the Director of Insurance must mail a notice of the decision to Aetna, you and your treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under your Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Department of Insurance is the expedited external independent reviewer.

Within 1 business day of receiving your request, Aetna must:

- Mail a written acknowledgement of your request to the Director of Insurance, you and your treating Provider.
- Send the Director of Insurance: the request for review, your Aetna Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna’s decision; a summary of the applicable issues including a statement of Aetna’s decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna’s utilization review guidelines.

Within 2 business days of receiving this information, the Director of Insurance must determine if the service or claim is covered, issue a decision, and send a notice to Aetna, you and your treating Provider.

The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs, the Director of Insurance will forward your case to an IRO. The IRO will have 72 hours to make a decision and send it to the Director of Insurance. The Director of Insurance will have 48 hours after receiving the IRO’s decision to send the decision to Aetna, you and your treating Provider.

Decision

Medical Necessity Decision:

If the IRO decides that Aetna should provide the service, Aetna must authorize the service. If the IRO agrees with Aetna’s decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Decision:

If you disagree with the Director of Insurance’s final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings (“OAH”). If Aetna disagrees with the Director’s final decision, Aetna may also request a hearing before the OAH. A hearing must be scheduled within 30 days of receiving the Director’s decision. OAH must promptly schedule and complete a hearing for Appeals from Expedited External Independent Medical Review Appeals decisions.

Standard appeal process for non-urgent and denied claims

Informal Reconsideration (Level One)

Your request: You may obtain Informal Reconsideration of your denied request for a service or a denied claim for services already provided to you if:

- You have coverage with us;
- We denied your request for a covered service or denied your claim for services already provided,
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for Informal Reconsideration within 2 years of the date we first deny the requested service or claim by calling, writing, or faxing your request to:

Name: Aetna Life Insurance
Title: Company
Dental Grievances and
Address: Appeals Unit
P.O. Box 14021, Lexington, KY
Phone: 40512-4021
Fax: 1-877-238-6200
859-455-8650

Our acknowledgement: Aetna has 5 business days after we receive your request for Informal Reconsideration (“the receipt date”) to send you and your treating provider a notice that we received your request.

Our decision: Aetna has the following timeframes after the receipt date within which to decide whether we should change our decision and authorize your requested service or pay your claim. Within that same timeframe, we must send you and your treating provider our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim within 15 calendar days – A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have 60 days to appeal to Level Two.**

If we deny your request for a Concurrent Care Claim Extension within 15 calendar days – A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have 60 days to appeal to Level Two.**

If we deny your request for a Post-Service Claim within 30 calendar days – A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have 60 days to appeal to Level Two.**

If we grant your request – The decision will authorize the service or pay the claim and the appeal process is complete.

If we refer your case to Level Three – We may decide to skip Level One and Level Two and send your case straight to an independent reviewer at Level Three.

You must exhaust the internal appeal process unless:

- We waive the exhaustion requirement
- We fail to comply with the requirements of the internal appeal process except for failures that are based on unimportant or minor violations

Formal Appeal (Level Two)

Your request: You may request a Formal Appeal if Aetna denied your request or claim at Level One. After you receive our Level One denial, you or your treating provider must send us a written request within 60 days to tell us you are appealing to Level Two. To help us make a decision on your appeal, you or your treating provider should also send us any more information (that you haven’t already sent us) to show why we should authorize the requested service or pay the claim.

A Member and/or an authorized representative may attend the Level Two Appeal hearing and question the representative of Aetna and/or any other witnesses, and present their case. The hearing will be informal. A Member’s Physician or other experts may testify. Aetna also has the right to present witnesses.

Send your appeal request and information to:

Name: Aetna Life Insurance
Title: Company
Dental Grievances and
Address: Appeals Unit
P.O. Box 14021, Lexington, KY
Phone: 40512-4021
Fax: 1-877-238-6200
859-455-8650

Our acknowledgement: Aetna has 5 business days after we receive your request for Formal Appeal (“the receipt date”) to send you and your treating provider a notice that we received your request.

Our decision: For a denied service that you have not yet received, Aetna has the following timeframes after the receipt date within which to decide whether we should change our decision and authorize your requested service. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request for a Pre-Service Claim – within 15 calendar days. A Pre-Service Claims is a claim for a benefit that requires approval of the benefit in advance of obtaining medical care. **You have four months to appeal to Level Three.**

If we deny your request for a Concurrent Care Claim Extension – within 15 calendar days. A Concurrent Care Claim Extension is a request to extend or a decision to reduce a previously approved course of treatment. **You have four months to appeal to Level Three.**

If we deny your request for a Post-Service Claim – within 30 calendar days. A Post-Service Claim is any claim for a benefit that is not a pre-service claim. **You have four months to appeal to Level Three.**

If we grant your request: We will authorize the service or pay the claim and the appeal process is complete.

If we refer your case to Level Three: We may decide to skip Level Two and send your case straight to an independent reviewer at Level Three.

External, Independent Review (Level Three)

Your request: You may obtain External Independent Medical Review only after you have sought any Appeals through standard and expedited Level One and Level Two. You have four months after receipt of written notice from Aetna that your Formal Appeal or Expedited Medical Review has been denied to request External Independent Medical Review. Your must send a written request for External Independent Medical Review and any material justification or documentation to support your request for the covered service or claim for a covered service to:

Name:	Priscilla Bugari, R.N.
Title:	Director, Aetna National External Review Unit
Address:	1100 Abernathy Rd, Suite 375, Atlanta, GA 30328
Phone:	1-877-848-5855 (Toll free)
Fax:	860-975-1526

Neither you nor your treating Provider is responsible for the cost of any External Independent Medical Review.

Process

There are 2 types of External Independent Medical Review Appeals, depending on the issues in your case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) you or your treating Provider are asking for, are not Medically Necessary to treat your condition or do not meet criteria for appropriateness, health care setting, level of care, or effectiveness of a covered benefit. The external independent reviewer is a Provider retained by an outside Independent Review Organization (“IRO”) that is procured by the Arizona Insurance Department, and not connected with Aetna. The IRO Provider must be one who typically manages the condition under review.

Within 6 business days of receiving your or the Director of Insurance’s request, or if Aetna initiates an External Independent Medical Review, Aetna must:

- Mail a written acknowledgement to the Director of Insurance, you and your treating Provider.
- Send the Director of Insurance: the request for review; your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna’s decision; a summary of the applicable issues including a statement of Aetna’s decision; the criteria used and clinical reasons for Aetna’s decision; and the relevant portions of Aetna’s utilization review guidelines. We must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier Appeal levels.

Within 5 business days of receiving Aetna information, the Director of Insurance must send all the submitted

information to the external independent review organization (the “IRO”).

Within 45 calendar days of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

Within 5 business days of receiving the IRO’s decision, the Director of Insurance will mail a notice of the decision to Aetna, you and your treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under your Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Department of Insurance is the external independent reviewer.

Within 6 business days of receiving your request or if Aetna initiates an External Independent Medical Review, Aetna must:

- Mail a written acknowledgement of your request to the Director of Insurance, you and your treating Provider.
- Send the Director of Insurance: the request for review, your Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna’s decision; a summary of the applicable issues including a statement of Aetna’s decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna’s utilization review guidelines.

Within 15 business days of receiving this information, the Director of Insurance will determine if the service or claim is covered, issue a decision, and send a notice of determination to Aetna, you and your treating Provider.

The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs or if the Director of Insurance finds that the case involves a medical issue, the Director of Insurance will forward your case to an IRO. The IRO will have 45 calendar days to make a decision and send it to the Director of Insurance. The Director of Insurance will have 5 business days after receiving the IRO’s decision to send the decision to Aetna, you and your treating Provider.

Decision

Medical necessity decision:

If the IRO decides that Aetna should provide the service, Aetna must authorize the service regardless of whether judicial review is sought. If the IRO agrees with Aetna decision to deny the service, the Appeal is over. Your only further option is to pursue your claim in Superior Court. However, on written request by the IRO, you or Aetna, the Director of Insurance may extend the 45-day time period for up to an additional 30 days, if the requesting party demonstrates good cause for an extension.

Contract coverage decision:

If you disagree with the Director of Insurance’s final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings (“OAH”). If Aetna disagrees with the Director’s final

decision, Aetna may also request a hearing before the OAH. A hearing must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

II. The role of the Director of Insurance.

Arizona law (A.R.S. §20-2533(F)) requires “any Member who files a Complaint or Appeal with the Department relating to an adverse decision to pursue the review process prescribed” by law. This means, that for decisions that are appealable, you must complete the health care Appeals process before the Director of Insurance can investigate a Complaint or Appeal you may have against Aetna based on the decision at issue in the Complaint or Appeal.

The Appeal process requires the Director to:

1. Oversee the Appeals process.
2. Maintain copies of each utilization review plan submitted by Aetna.
3. Receive, process, and act on requests from Aetna for External Independent Medical Review.
4. Enforce the decisions of Aetna.
5. Review decisions of Aetna.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an Appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at the OAH.

III. Obtaining medical records.

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of their medical records. Your request must be in writing and must specify who you want to receive the records. The health care Provider who has your records will provide you or the person you specify with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical

records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to you or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the Appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

IV. Documentation for an appeal.

If you decide to file an Appeal, you must give us any material justification or documentation for the Appeal at the time the Appeal is filed. If you gather new information during the course of your Appeal, you should give it to us as soon as you receive it. You must also give Aetna the address and phone number where you can be contacted. If the Appeal is already at Expedited External Independent Medical Review, you should also send the information to the Department.

V. Receipt of documents.

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed (your last known address) on the fifth business day after being mailed.

VI. Record retention.

Aetna shall retain the records of all Complaints and Appeals for a period of at least 7 years.

VII. Fees and costs.

Nothing herein shall be construed to require Aetna to pay counsel fees or any other fees or costs incurred by you in pursuing a Complaint or Appeal.

Submit completed forms to:

For Expedited & Standard Level 1 and Level 2
Aetna Health Inc./Aetna Health Insurance Company
Customer Resolution Team
P.O. Box 14021, Lexington, KY 40512-4021
Fax: 859-455-8650

For Expedited & Standard External Independent Review (Level 3)
Priscilla Bugari, R.N.
Director, Aetna National External Review Unit
1100 Abernathy Road, Suite 375, Atlanta, GA 30328
Phone: 1-877-848-5855 (Toll-free number)
Fax: 860-975-1526

Dental Care Appeal Request Form

(You may use this form to tell your insurer you want to appeal a denial decision.)

Insured Member's Name _____ Member ID# _____

Name of representative pursuing appeal, if different from above _____

Mailing Address _____ Phone # _____

City _____ State _____ Zip Code _____

Type of Denial: _____ Denied Claim for Service Already Provided _____ Denied Service Not Yet Received

Name of Insurer that denied the claim/service: _____

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "yes", you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? (Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim or service should be covered:

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number, **602-364-2499** or **1-800-325-2548** (inside Arizona but outside the Phoenix area) or via the Internet at **www.azinsurance.gov**. You may also call the Aetna Member Services number on the member's ID card.

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including:
_____ Dental records _____ Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.)

** Also attach the certification from your treating provider if you are seeking expedited review.

Signature of insured or authorized representative

Date

Submit completed forms to:

Aetna Health Inc./Aetna Health Insurance Company
Dental Grievance and Appeals Unit
P.O. Box 14021, Lexington, KY 40512-4021
Fax: 859-455-8650

Provider Certification Form For Expedited Medical Reviews

(You and your provider may use this form when requesting an expedited appeal.)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 30 days) “is likely to cause a significant negative change in the [patient’s] medical condition at issue.”

PROVIDER INFORMATION

Treating Physician/Provider _____
Phone # _____ FAX # _____
Address _____
City _____ State _____ Zip Code _____

PATIENT INFORMATION

Patient’s Name _____ Member ID # _____
Phone # _____
Address _____
City _____ State _____ Zip Code _____

INSURER INFORMATION

Insurer Name _____
Phone # _____ FAX # _____
Address _____
City _____ State _____ Zip Code _____

- Is the appeal for a service that the patient has already received? Yes No
 If “Yes”, the patient must pursue the standard appeals process and cannot use the expedited appeals process.
 If “No”, continue with this form.

- What service denial is the patient appealing?

- Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient.

Attach additional sheets, if needed, and include: Medical records Supporting documentation

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number **602-364-2499** or **1-800-325-2548** (inside Arizona but outside the Phoenix area) or via the Internet at **www.azinsurance.gov**. You may also call the Aetna Member Services number on the member’s ID card. For plans subject to the Patient Protection and Affordable Care Act (PPACA), if you have questions about your appeal rights, this notice, or for assistance, you can also contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272)**.

I certify, as the patient’s treating provider, that delaying the patient’s care for the time period needed for the Level One and Level Two appeal processes (about 30 days) is likely to cause a significant negative change in the patient’s medical condition at issue.

Provider’s signature

Date

Notes

**If you need this material translated into another language, please call Member Services at 1-800-323-9930.
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-800-323-9930.**

www.aetna.com

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