



Aetna Provider Appeals Process

Aetna has designed a set of step-by-step instructions to question or appeal a claim payment or clinical decision. The process includes a reconsideration step as well as levels for an appeal. The procedures apply to individual practitioners as well as organizational providers such as hospitals and other facilities. The process applies to all Aetna medical benefits products.

The telephone number for Aetna is 888-632-3862. The mailing address for correspondence related to appeals is P.O. Box 981109, Lexington, KY 40512

Reconsideration: Reconsideration is the first step in questioning a claim payment decision. The provider must contact Aetna's Provider Service Center (PSC) within 180 days of the receipt of the initial claim determination. Have the Aetna EOB available for reference when contacting Aetna.

Aetna will provide a written or verbal response within three to five business days and if the decision is in the provider's favor, Aetna will also recalculate and reprocess the claim for affected services. In some instances, Aetna will forward the claim to a specialty unit for review. A response will be completed within 30 business days unless additional information is requested.

If the matter is not decided in the provider's favor, a Level I appeal may be initiated. Details on how to file the appeal will be provided when the reconsideration decision is given to the provider.

Appeals Process: Aetna's appeal process consists of two levels. The Level I appeal must be filed within 60 days of receipt of an adverse reconsideration decision. The Level II appeal must be filed within 60 days of receipt of an adverse Level I decision. In both Level I and Level II appeals, Aetna has 30 business days after receipt of the appeal to issue its written decision to the provider. If the decision is in the provider's favor, Aetna will also recalculate and reprocess the claim for affected services.

Aetna has established Post-Appeal reviews, which under specific circumstances are available for reviews by an external organization. These appeals include the Billing Dispute Resolution Process and the Medical Necessity External Review Process.

Pre-Service Appeals: A pre-service appeal involves a decision reached by Aetna during the pre-certification process. An expedited appeal process is also available for urgent or ongoing services, and the decision is rendered within 36 hours after the receipt of the appeal, unless state mandates require a shorter time period.