

# HEALTH APPEAL PACKET NO. 2

## Level 2 Appeal to Aetna or OptumRx (Active Employee Plan)

There are 4 levels of appeal for denied health or pharmacy claims. Each level has its own packet of instructions and forms. **This packet is for level 2.** You must follow the appeal process **in the correct order** and **on time**. You may withdraw your appeal at any step.

<i>Form Number</i>	<i>Form Name</i>
<b>INSTRUCTIONS</b>	
Instructions start on the next page. Your level 2 appeal will be <b>either</b> a REQUEST FOR EXTERNAL REVIEW <b>or</b> a LEVEL 2 APPEAL, <b>depending</b> on the reason why your level 1 appeal was denied. For more instructions, see the appeal section of the health <a href="#">PLAN</a> .	
<b>FORMS DISCUSSED IN THIS PACKET</b>	
<a href="#">HCA-205</a>	<p><b>Level 2 Appeal of Medical Necessity Denial (Request for External Review)</b></p> <p>Use this form if <b>Aetna</b> denied your level 1 appeal because Aetna thinks the services your provider ordered are <u>not medically necessary</u>. It is not for emergency appeals.</p>
<a href="#">HCA-105</a>	<p><b>Level 2 Appeal of Other Health Claim Denial</b></p> <p>Use this form if <b>Aetna</b> denied your level 1 appeal for a <u>reason different than medical necessity</u>, or if <b>OptumRx</b> (or Briova) denied your level 1 appeal of a pharmacy claim. Here are some examples of non-pharmacy appeals that are different than medical necessity:</p> <ul style="list-style-type: none"> <li>▪ Aetna thinks your doctor charged too much (recognized charge);</li> <li>▪ You used an out-of-network hospital in Anchorage; or</li> <li>▪ The health <a href="#">PLAN</a> does not cover the medical procedure.</li> </ul>
<b>OTHER TOOLS AND PACKETS</b>	
<a href="#">Flowchart</a>	<a href="https://public.courts.alaska.gov/web/forms/docs/wfd-aetna.pdf">https://public.courts.alaska.gov/web/forms/docs/wfd-aetna.pdf</a>
<a href="#">Links</a>	<a href="https://public.courts.alaska.gov/web/forms/docs/hcatoolkit-links.pdf">https://public.courts.alaska.gov/web/forms/docs/hcatoolkit-links.pdf</a>
<a href="#">Level 1 Packet</a>	<a href="https://public.courts.alaska.gov/web/forms/docs/hca-100.pdf">https://public.courts.alaska.gov/web/forms/docs/hca-100.pdf</a>
<a href="#">Level 3 Packet</a>	<a href="https://public.courts.alaska.gov/web/forms/docs/hca-300.pdf">https://public.courts.alaska.gov/web/forms/docs/hca-300.pdf</a>
<a href="#">Level 4 Packet</a>	<a href="https://public.courts.alaska.gov/web/forms/docs/hca-400.pdf">https://public.courts.alaska.gov/web/forms/docs/hca-400.pdf</a>

### March 2019-Alaska Court System

This packet was prepared by the healthcare advocates at the Alaska Court System for employees of the Alaska Court System and their dependents who are members of the AlaskaCare Active Employee Plan. For more information or assistance, please email: [HealthcareAdvocates@akcourts.us](mailto:HealthcareAdvocates@akcourts.us).

## HOW TO FILE A LEVEL 2 APPEAL AFTER YOUR LEVEL 1 APPEAL IS DENIED

<b>INTRODUCTION</b>	
<b>What is this packet for?</b>	<p><b>Use this packet:</b></p> <ul style="list-style-type: none"> <li>▪ If you want to appeal a health claim that Aetna or OptumRx denied or partially denied, or a pre-certification request that Aetna or OptumRx denied; <u>and</u></li> <li>▪ You already submitted a level 1 appeal and it was denied by Aetna or OptumRx; <u>and</u></li> <li>▪ You are an active employee of the Alaska Court System or a dependent.</li> </ul> <p><b>Do <u>not</u> use this packet:</b></p> <ul style="list-style-type: none"> <li>▪ This packet is <u>not</u> for emergency appeals. For help with emergency appeals, refer to the health <a href="#">PLAN</a> or e-mail the Healthcare Advocates.</li> <li>▪ This packet is <u>not</u> for dental or vision appeals. For help with those, refer to the health <a href="#">PLAN</a> or e-mail the Healthcare Advocates.</li> <li>▪ This packet is not for level 1 appeals to Aetna or OptumRx. Use form <a href="#">HCA-100, Health Appeal Packet 1</a> for those.</li> <li>▪ This packet is <u>not</u> for level 3 appeals. Use form <a href="#">HCA-300, Health Appeal Packet 3</a> for those.</li> <li>▪ This packet is also <u>not</u> for appeals to superior court. Use form <a href="#">HCA-400, Health Appeal Packet 4</a> for those.</li> </ul>
<p><b>What are the basic steps for appealing?</b></p> <p><b>This packet is for step 2.</b></p>	<p>The active employee health plan for 2018 includes a new level of appeal. For services received on or after January 1, 2018, there are 4 levels of appeal. This includes 2 appeals through Aetna for health services or OptumRx for pharmacy services, 1 appeal to DRB, and then 1 appeal to court. (For services received before January 1, 2018, there are 3 levels of appeal.) You must go through each level of appeal <b>in the correct order</b>, and <b>on time</b>. You may withdraw your appeal at any step.</p> <p><b>Step 1</b> is a LEVEL 1 APPEAL to Aetna for health services or OptumRx for pharmacy services. For level 1 appeals, use form <a href="#">HCA-100, Health Appeal Packet 1</a>. If your level 1 appeal is granted, then you won, and the process is finished. If your level 1 appeal is denied, then go to step 2.</p> <p><b>Step 2</b> will be <b>either</b> a LEVEL 2 APPEAL to Aetna or OptumRx, <b>or</b> a REQUEST FOR EXTERNAL REVIEW to Aetna, <b>depending</b> on the reason why your level 1 appeal was denied.</p> <ul style="list-style-type: none"> <li>▪ <b>IMPORTANT!</b> Step 2 is a REQUEST FOR EXTERNAL REVIEW to Aetna if Aetna denied your level 1 appeal because Aetna thinks your provider ordered services that are <u>not medically necessary</u>, as defined in Section 3.5.1 of the <a href="#">PLAN</a>. Sometimes Aetna denies claims as not medically necessary because you or your provider did not request pre-certification.</li> </ul> <p style="text-align: center;"><b>-OR-</b></p> <ul style="list-style-type: none"> <li>▪ Step 2 is a LEVEL 2 APPEAL to Aetna for health services or OptumRx for pharmacy services if your level 1 appeal was denied for a <u>reason different than medical necessity</u>. Here are some examples:             <ul style="list-style-type: none"> <li>▪ Aetna thinks your doctor charged too much (“recognized charge”);</li> <li>▪ You used an out-of-network hospital in Anchorage; or</li> <li>▪ The <a href="#">PLAN</a> does not cover the medical procedure or drug.</li> </ul> </li> </ul>

**Step 3** is only for services received on or after January 1, 2018, and will be a LEVEL 3 APPEAL to DRB. For step 3, use [HCA-300, Health Appeal Packet 3](#). If your Level 3 appeal is denied, or the services were before 2018 go to Step 4.

**Step 4** is filing an appeal to SUPERIOR COURT if you do not win at the earlier steps. For appeals to superior court, use [HCA-400, Health Appeal Packet 4](#).

**FIND THE LEVEL 1 DENIAL LETTER**

**Find your Level 1 denial letter from Aetna or Optum Rx.**

Aetna or OptumRx mailed you a letter explaining that your level 1 appeal was denied. In that denial letter, Aetna or OptumRx should explain the reason why and what you can do next.

**IMPORTANT!!!**

- Was your level 1 appeal denied because the services or medications your provider ordered are not medically necessary? (Look specifically in the denial letter for the words “medical necessity” or “medically necessary.”) If so, your next step is to file a **REQUEST FOR EXTERNAL REVIEW** which is basically an appeal of a medical necessity denial. Aetna’s level 1 denial letter will tell you this and give you a non-fillable form to use. You may instead use the court’s fillable version if you wish. **If OptumRx’s denial letter says your next step is to request an external review, then email the [healthcareadvocates@akcourts.us](mailto:healthcareadvocates@akcourts.us) for more information.**

**--or--**

- If Aetna or OptumRx denied your level 1 appeal for any reason different than medical necessity, your next step is to file a **LEVEL 2 APPEAL**.

**DEADLINE FOR SUBMITTING THE LEVEL 2 APPEAL**

**When is my level 2 appeal due?**

You have a limited amount of time to submit your level 2 appeal. **VERY IMPORTANT!!!** The deadline depends on the reason why your level 1 appeal was denied:

- If your level 1 appeal was denied because the services or medications are not medically necessary, then you have **4 months** from the date of the level 1 denial letter to send your request for external review.
- If your level 1 appeal was denied for any reason different than medical necessity, then you have **180 days** after the date you received Aetna’s or OptumRx’s level 1 denial letter to send in your level 2 appeal.

Calculate your deadline using the date of the level 1 appeal denial letter. For a medical necessity denial, count ahead 4 months from the date of the denial letter. For a health claim denial, you may use the online date calculator available at: <http://cgi.cs.duke.edu/~des/datecalc/datecalc.cgi>. Type the date of the health claim denial letter as your start date, and then type 180 days as the number of days. Then click “submit” to learn your deadline. There is an example at the top of the next page.

--	--

**LEVEL 2 APPEAL OF MEDICAL NECESSITY DENIAL**  
**(Request for External Review)**

**Prepare the request for external review.**

**If your level 1 appeal was denied because the procedure or medication your provider recommended is not "medically necessary," then request external review by following these 5 steps:**

1. FOR LEVEL 1 DENIAL BY AETNA, USE FORM [HCA-205](#). FOR LEVEL 1 DENIAL BY OPTUMRx, USE THE [HCA-105](#)  
 Fill out all relevant sections. Then sign and date it. If you need more space to describe your request, use more pages and attach them. If you do this, be sure you say "More Pages Attached." For examples of language you might use for a request for external review, email the healthcare advocates at [HealthcareAdvocates@akcourts.us](mailto:HealthcareAdvocates@akcourts.us).  
**IMPORTANT!!!** If you have more than one plan (such as both active and retiree plans), write all your member ID numbers on the form.
2. GATHER MEDICAL RECORDS FROM YOUR PROVIDER. Decide what documents to include with your request for external review. Sometimes you only need to re-send the same records you sent with your level 1 appeal. Other times, depending on what it says in the level 1 denial letter, you might want to add something else.  
  
 Just because you already sent Aetna or OptumRx your medical records with your level 1 appeal, **DO NOT ASSUME** that they will include those records when they assign your case to an external review company. Always make sure that you provide copies of your records and tell Aetna or OptumRx to give them to the external review company. Check with the healthcare advocates if you need more information about this step: [HealthcareAdvocates@akcourts.us](mailto:HealthcareAdvocates@akcourts.us).
3. MAKE A COPY FOR YOUR RECORDS OF ALL LEVEL 2 DOCUMENTS YOU WILL SUBMIT IN CASE YOU DECIDE TO APPEAL TO SUPERIOR COURT LATER.
4. SUBMIT YOUR REQUEST FOR EXTERNAL REVIEW. Make sure to send it by fax with a confirmation sheet, or by U.S. mail with delivery confirmation to the number or address on the form. You need to be able to prove that your request was received within the appeal deadline.
5. CONTACT FROM THE EXTERNAL REVIEW COMPANY. Sometimes external review companies are also called "independent review organizations." Usually the external review company will mail you a letter telling you that it was

<p><b>Learning the result of the external review.</b></p>	<p>assigned to your appeal and invite you to submit any more information you think will be helpful. Just in case Aetna (or OptumRx) fails to send your records, you may send the external review company every medical record or statement from your provider that you think will help them do their review.</p> <p>Aetna or OptumRx will mail you a letter with the results of any external review. The external review company will also mail you a copy of the letter. The letter will either overturn or uphold the Level 1 denial.</p> <p>If the external review company <i>overturns</i> the level 1 denial, it means that you won your appeal. If the external review company <i>upholds</i> Aetna’s denial, it means you did not win the appeal. Also, your next step depends on when the services or supplies were received (remember, the Plan changed in 2018):</p> <ul style="list-style-type: none"> <li>• If your appeal is about services or supplies received <b>on or after January 1, 2018</b>, then your next step is to file a Level 3 appeal to DRB. Use form <a href="#">HCA-300, Health Appeal Packet 3</a>, or email the healthcare advocates at <a href="mailto:HealthcareAdvocates@akcourts.us">HealthcareAdvocates@akcourts.us</a>.</li> </ul> <p style="text-align: center;"><b>--or--</b></p> <ul style="list-style-type: none"> <li>• If your appeal is about services or supplies received <b>before 2018</b>, then your next step is to appeal directly to Superior Court. Use form <a href="#">HCA-400, Health Appeal Packet 4</a>, or email the healthcare advocates at <a href="mailto:healthcareadvocates@akcourts.us">healthcareadvocates@akcourts.us</a>.</li> </ul>
---	--

**LEVEL 2 APPEAL OF HEALTH CLAIM DENIAL**

<p><b>Prepare the level 2 appeal.</b></p>	<p><b>If Aetna or OptumRx denied your level 1 appeal, and the reason for denial was <u>not</u> about “medical necessity,” you can file a level 2 appeal by following these 5 steps:</b></p> <ol style="list-style-type: none"> <li>1. <u>FILL OUT FORM HCA-105</u> to prepare your level 2 appeal. (This is the same form you used for your level 1 appeal.) Fill out each section that applies. Then sign and date the last page, and fill in your contact information.  For examples of language you might use for an appeal of a denied health claim, email the healthcare advocates: <a href="mailto:HealthcareAdvocates@akcourts.us">HealthcareAdvocates@akcourts.us</a>.</li> <li>2. <u>GATHER MEDICAL RECORDS FROM YOUR PROVIDER</u>. Decide what documents to include with your level 2 appeal. Sometimes you only need to re-send the same records you sent with your level 1 appeal. Other times, depending on what Aetna said in its level 1 denial letter, you might want to add something else. Check with your provider or the healthcare advocates if you need more information about this step.</li> <li>3. <u>MAKE A COPY FOR YOUR RECORDS OF ALL LEVEL 2 DOCUMENTS THAT YOU SUBMIT IN CASE YOU DECIDE TO APPEAL TO SUPERIOR COURT LATER</u>.</li> <li>4. <u>SUBMIT YOUR LEVEL 2 APPEAL TO AETNA OR OPTUMRx</u>. Make sure to send your level 2 appeal by fax with a confirmation sheet, or by U.S. mail with delivery confirmation. You need to be able to prove that Aetna or OptumRx received it within the appeal deadline.</li> <li>5. <u>KEEP TRACK OF YOUR LEVEL 2 APPEAL</u>. Contact Aetna after about a month if you have not yet received a decision letter.</li> </ol>
---	---

<b>Learning the result of your level 2 appeal.</b>	<p>Aetna or OptumRx will mail you a letter with the results of your level 2 appeal. If your level 2 appeal is denied, the letter will explain why and what to do next.</p> <ul style="list-style-type: none"><li>• If your appeal is about services or supplies received <b>on or after January 1, 2018</b>, your next step is to file a Level 3 appeal to DRB. Use form <a href="#">HCA-300, Health Appeal Packet 3</a>, or email the healthcare advocates at: <a href="mailto:HealthcareAdvocates@akcourts.us">HealthcareAdvocates@akcourts.us</a>.</li><li>• If your appeal is about services or supplies received <b>before 2018</b>, then your next step is to skip to Level 4. Use form <a href="#">HCA-400, Health Appeal Packet 4</a> for appeals to superior court.</li></ul>
--	--

**When in doubt, email the healthcare advocates at [HealthcareAdvocates@akcourts.us](mailto:HealthcareAdvocates@akcourts.us)**



# Request for External Review

**Aetna and/or Aetna Life Insurance Company**  
National External Review Unit  
2000 River Edge Parkway  
Suite 300  
Atlanta, GA 30328  
**Phone:** (877) 848-5855 **Fax:**  
(860) 975-1526

## Instructions

As a plan member, you can appeal an Aetna internal coverage decision by requesting an External Review. Please attach a copy of your Plan denial of coverage letter and all other information you want the reviewer to consider. You can submit your request to the mailing address or fax number listed above.

## My Information

My name		My Aetna member ID Number	
My street	city	state	ZIP code
My phone numbers		Home ( ) - Mobile ( ) -	

## My Provider's Information

Provider name			
Provider street	city	state	ZIP code
Provider phone numbers		Office ( ) - Fax ( ) -	

## External Review Request

I'm requesting an external review for the following coverage denial:

  
  
  
  
  
  
  
  
  
  
**NOTE:** Attach copy of coverage denial and all other information you wish to have considered.

## Signature(s)

By signing below, I consent to the release of all confidential medical information by Aetna or an affiliated entity and my healthcare providers to the Independent Review Organization (IRO) and its reviewers. My consent includes consent to release all confidential information relating to mental/behavioral health, substance abuse and HIV/AIDS, if applicable. My consent is valid for one year, and I may revoke it at any time by giving written notice to Aetna.

I understand that if I choose to have someone sign below as "My Authorized Representative", I consent that he/she may request an External Review on my behalf, and that he/she will receive all follow-up communication(s) about the request.

<b>My Signature</b>		Phone number	
<b>My Legal Representative's signature*</b> <b>*Parent, Guardian, Conservator, or Other (Please specify):</b>		Phone number	
Printed name		Date	
<b>My Authorized Representative's signature</b>		Phone number	
Printed name		Date	
Street (if different than the Member's)	city	state	ZIP code

Certain states mandate separate external review processes. External review of additional benefits or services may require a filing fee or a different form. Contact Member Services at the number listed on your identification card or call your state insurance or health department for additional information about state mandated external review procedures. These state mandates may not apply to self-funded plans. You can find out more about external reviews by visiting our website ([www.aetna.com](http://www.aetna.com)) or by calling Member Services.

Your Member Number: \_\_\_\_\_

Your Name: \_\_\_\_\_

## APPEAL OF HEALTH CLAIM OR PRECERTIFICATION DENIAL

This form is for active employees (not retirees) of the Alaska Court System and their dependents who wish to appeal health claim or precertification denials by Aetna or OptumRx.

### WHAT LEVEL APPEAL IS THIS?

[For more information about appealing your claims, call DRB at 1-800-821-2251; or review the health plan at <http://doa.alaska.gov/dr/alaskacare/employee/publications/booklet.html>; or email the Healthcare Advocates at [healthcareadvocates@akcourts.us](mailto:healthcareadvocates@akcourts.us). If you are not satisfied with the administrative appeal decisions, you may appeal to Superior Court. See appeal form packets [HCA-100](#), [HCA-200](#), [HCA-300](#), and [HCA-400](#).]

**Level 1 Appeal to  Aetna  OptumRx**  **Check this box if this is an urgent appeal** \*  
Check this box if this is your Level 1 (first) appeal of a claim denied in full or in part by Aetna for health services or OptumRx for drugs. Level 1 appeals must be **received** by Aetna or OptumRx within 180 calendar days of the Explanation of Benefits (EOB) "statement date" or denial letter. You may use this [online calculator](#) to calculate the due date.

**Level 2 Appeal to  Aetna  OptumRx**  **Check this box if this is an urgent appeal** \*  
Check this Level 2 box if **all** of these statements are true:  
a. You are not satisfied with the level 1 appeal decision by Aetna or OptumRx; and  
b. For Aetna claims only, Aetna's level 1 decision was based on something other than Aetna's "medical opinion" (for example, Aetna says your doctor's charges are more than the "recognized charge," or the service you received is not covered by the plan, or that they need more records from your doctor); and  
c. You want to appeal to level 2.  
Level 2 appeals go to Aetna for denied health services or OptumRx for denied drugs, and must be **received** by Aetna or OptumRx within 180 calendar days of the date of the Level 1 decision. You may use this [online calculator](#) to calculate the due date.

**Level 2 Request for External Review to Aetna**  **Check this box if this is an urgent appeal** \*  
Check this box if **all** of these statements are true:  
a. You are not satisfied with the level 1 appeal decision by Aetna; and  
b. Aetna's level 1 decision was based on Aetna's "medical opinion" or Aetna's level 1 denial letter talks about "medical necessity" (for example, they say your procedure was not medically necessary, or it was experimental or investigational, or something else involving Aetna's medical or clinical opinion); and  
c. You want to request review by an independent external review company.  
Requests for external review must be submitted to Aetna no later than 4 months after you receive the level 1 denial letter. Aetna is supposed to send a copy of their form for requesting these but they don't always do that. If you do not receive a form from Aetna, use this form or form [HCA-205](#) instead, or email the Healthcare Advocates.

**Level 3 Appeal to DRB (new for 2018)**  **Check this box if this is an urgent appeal** \*  
Check this box if **all** of these statements are true:  
a. You are appealing denial of services or pre-service request provided on or after January 1, 2018; and  
b. You are not satisfied with the level 2 appeal denied by Aetna or OptumRx, or you are not satisfied with the external review by Aetna; and  
c. You want to appeal to level 3.  
Level 3 only applies to services received after 2017. For services received before 2018, skip level 3 and go directly to level 4 (appeal to superior court). Level 3 appeals go to the Division of Retirement & Benefits (DRB) and must be received by the DRB within 60 calendar days of the date of the external review or level 2 decision. You may use this [online calculator](#) to calculate the due date.

**Level 4 Appeal to Superior Court.** If you did not succeed at each of the levels below, then you may appeal to the superior court using packet [HCA-400](#), Health Appeal Packet 4.

\* Request an urgent appeal if you believe that a delay in the appeal process could harm health or threaten life.



Your Member Number: \_\_\_\_\_

Your Name: \_\_\_\_\_

## HOW AND WHERE TO SUBMIT THIS APPEAL

I am sending my appeal today by mail and/or fax as noted below.

**LEVEL 1 OR LEVEL 2 APPEAL TO AETNA**  
Fax with confirmation to (859) 425-3379  
Mail with delivery confirmation to:  
Aetna  
Attn: AlaskaCare Member Appeal  
PO Box 14463  
Lexington, KY 40512

**LEVEL 1 OR LEVEL 2 APPEAL TO OPTUMRX**  
Mail with delivery confirmation to:  
OptumRx  
Attn: AlaskaCare Benefit Appeals  
PO Box 3410  
Lisle, IL 60532-8410

**LEVEL 4 APPEAL TO SUPERIOR COURT**  
File your Level 4 appeal at your nearest Superior Court location. Follow Instructions in the HCA-400 packet. You will also need to serve a copy on DRB and AK Dept. of Law

**REQUEST FOR EXTERNAL REVIEW TO AETNA**  
Fax with confirmation to (860) 975-1526  
Mail with delivery confirmation to:  
Aetna  
Attn: National External Review Unit  
2000 River Edge Parkway, Ste. 300  
Atlanta, GA 30328

**LEVEL 3 APPEAL TO DRB**  
Fax to (907) 465-2805  
Mail with delivery confirmation to:  
Division of Retirement & Benefits  
Attn: AlaskaCare Member Appeal  
PO Box 110203  
Juneau, AK 99811

## WHAT CLAIMS ARE BEING APPEALED?

**AETNA APPEALS:** When a doctor sends a bill to Aetna for payment, Aetna creates an “explanation of benefits” (EOB) statement. Find EOBs at <https://www.Aetna.com/> after logging in. Every EOB has a statement date in the top right corner of the 1st page; and every claim on the EOB has a claim ID number. Every letter from Aetna denying precertification has a case number. **OPTUMRX APPEALS:** You will learn of an OptumRx denial because your pharmacist tells you or you receive a denial letter from OptumRx. There may or may not be a case number, but try and fill out the information below. For more information, email [HealthcareAdvocates@akcourts.us](mailto:HealthcareAdvocates@akcourts.us).

I am appealing the full or partial denial of the following precertification or health claims:

1. Claim or case number \_\_\_\_\_  
Statement date \_\_\_\_\_  
Date of service \_\_\_\_\_  
Provider \_\_\_\_\_  
Drug denied by OptumRx/Briova (if any):  
\_\_\_\_\_

2. Claim or case number \_\_\_\_\_  
Statement date \_\_\_\_\_  
Date of service \_\_\_\_\_  
Provider \_\_\_\_\_  
Drug denied by OptumRx/Briova (if any):  
\_\_\_\_\_

3. Claim or case number \_\_\_\_\_  
Statement date \_\_\_\_\_  
Date of service \_\_\_\_\_  
Provider \_\_\_\_\_  
Drug denied by OptumRx/Briova (if any):  
\_\_\_\_\_

4. Claim or case number \_\_\_\_\_  
Statement date \_\_\_\_\_  
Date of service \_\_\_\_\_  
Provider \_\_\_\_\_  
Drug denied by OptumRx/Briova (if any):  
\_\_\_\_\_

Your Member Number: \_\_\_\_\_

Your Name: \_\_\_\_\_

**WHO IS THIS APPEAL ABOUT?**

My member ID # on my Aetna card is \_\_\_\_\_ My date of birth is \_\_\_\_\_

I am appealing the denial of health services or precertification concerning:

myself. My name is \_\_\_\_\_

my spouse (name and date of birth) \_\_\_\_\_

my child (name and date of birth) \_\_\_\_\_

other (name and date of birth) \_\_\_\_\_

**WHAT ELSE IS INCLUDED WITH THIS APPEAL?**

I am submitting more information and documents with this appeal as follows:

- correspondence
- copy of medical records
- copy or copies of EOB's (explanation of benefits statements)
- copy of prior level appeal denial letter
- other (describe)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

By referring to it here, I incorporate all information my provider and I submitted before; this filled-out form; the *Insurance Information Booklet* and all addenda and clarifications in effect on the relevant dates of service; the related Optum Fee Analyzer reports; and any enclosed documents. I also incorporate all recordings related to my appeal and my claims, and ask you to preserve the recordings and all related information until further notice. I also request access to copies of all documents, records, data, and other information about my claims whether or not used in making the decision, and the names of any clinical reviewers if applicable.

I spoke with Aetna or OptumRx about this claim or claims as follows:

Date	Call Reference No.	Representative's Name/ID
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Your Member Number: \_\_\_\_\_

Your Name: \_\_\_\_\_

## DATA AND DOCUMENTS REQUESTED AS PART OF THIS APPEAL

- A. Recognized charge.** This paragraph applies if my claim(s) were denied in whole or part as above the “recognized charge.” The database used for setting the recognized charge is inconsistent with any usual, customary, reasonable, or prevailing rate in the geographic area where the services were performed. The plan relies on data from a database known to be incomplete, inaccurate, and indefensible. I request the following as part of my appeal: (1) For each of the past 36 months, how many actual claims were submitted by Alaska providers on behalf of active and retired AlaskaCare plan members for each of the same CPTs or medications denied in whole or part as above the recognized charge in my claim? And of these actual claims submitted, how many were denied in whole or part as above the recognized charge? (2) Which FairHealth update (May or November, and of what year) was used to process the claims I am appealing? (3) Was “derived data” used to determine the recognized charge for my claims? If so, for each CPT or medication, how many frequencies were in the database on the date my claims were processed and what were the actual provider charge amounts and dates of each of those frequencies? (4) Provide me with a copy of all correspondence between any employee of the Alaska Dept. of Administration and any employee of Aetna or OptumRx about any of the following: FairHealth, any rate-setting database other than FairHealth, and Aetna’s or OptumRx’s reimbursement policies and practices regarding the recognized charge or similar rate-setting tool or process. (5) Provide a copy of the contract or letter of agreement between Alaska and Aetna, or for pharmacy claims between Alaska and OptumRx in effect on the dates of service associated with my claims. (6) Identify the Medicare reimbursement rate in effect on the dates of service for the CPTs or medications at issue in my claim. (7) Identify and provide a copy of every other document or source of information other than the FairHealth database that was used to process my claims.
- B. Proprietary guidelines or clinical policy bulletins.** This paragraph applies if my claim or claims were denied because of information in proprietary documents or guidelines (for example, the MCG Guidelines or the Milliman Medicare Repricer) or a clinical policy bulletin. Please follow all necessary protocols and promptly release the documents and guidelines to me because they are being used to my detriment.
- C. Medical records.** This paragraph applies if my medical records were overlooked or ignored by Aetna or OptumRx or its external review organization in making the adverse benefit determination referenced in this appeal. Provide a copy of my medical records (1) in Aetna’s or OptumRx’s possession or control whether or not used to process my claim, and (2) actually reviewed or used by Aetna’s or OptumRx’s system, external review organization, or employee to process my claim. In addition, if Aetna’s or OptumRx’s system processed my claim, I ask that this appeal and my future claims be processed by a human instead.
- D. Network steerage.** This paragraph applies if my claim(s) were denied in whole or part as out of network. Provide all information used in determining that my provider was out of network. If non-network facility penalties were applied to my claim(s), confirm that the penalties were applied pursuant to my plan(s) and the law, and for facilities in Anchorage or the other 49 states.

**E. Other information requested:**

---

---

---

---

---

---

---

---

## DATE AND SIGN THIS APPEAL

Today’s Date \_\_\_\_\_

Your Name \_\_\_\_\_ Your Telephone \_\_\_\_\_

Your Mailing Address \_\_\_\_\_

Your Signature \_\_\_\_\_