

# Member Complaint and Appeal Form

**NOTE:** Completion of this form is voluntary. To obtain a review, you or your authorized representative may also call our Member Services Department using the telephone number displayed on the member ID card or submit a request in writing to the address listed at the end of your Explanation of Benefits (EOB) or other correspondence received from Banner|Aetna.

**Please provide the following information for the primary Insured/Member.**  
*(This information may be found on the front of your ID card.)*

Today's Date	Member's ID Number	Plan Type <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Member's Group Number <i>(Optional)</i>
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Member's First Name	Member's Last Name	Member's Birthdate <i>(MM/DD/YYYY)</i>
Member's E-mail Address		

**Please provide the following information for the person you are submitting the request for.**

First Name	Last Name	Birthdate <i>(MM/DD/YYYY)</i>
Relationship to person requesting the appeal: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		
<b>Note:</b> If your selection is spouse, child (18 years of age or older) or other, please complete and include the attached Authorized Representative Form with your request.		
Please advise if the appeal is related to: <input type="checkbox"/> Pre-Service <input type="checkbox"/> Post Service		

**To help us review and respond to your request, please provide the following information.**  
*(This information may be found on correspondence from us.)*

Claim ID Number <i>(If Post Service selected above.)</i>	Reference Number <i>(If Pre-Service selected above.)</i>	Service Date <i>(If Post Service insert date of services, if Pre-Service insert date of denial.)</i>
Explanation of Your Request <i>(Please use additional pages if necessary.)</i>		
Member's Signature		

**Note:** When submitting this form with your request please include: - Bills and/or correspondence for these services.  
 - Any other helpful information.

You may mail your request to: **Banner| Aetna**  
**PO Box 14463**  
**Lexington, KY 40512**

**Or use our National Fax Number: 859-425-3379CRTM**

## **Nondiscrimination Notice**

Banner|Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator  
P.O. Box 14462, Lexington, KY 40512  
1-800-648-7817, TTY: 711  
Fax: 859-425-3379  
E-mail: [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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