



# 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 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 (Optional)
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Member's First Name	Member's Last Name	Member's Birthdate (MM/DD/YYYY)
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**Please provide the following information for the person you are submitting the request for.**

First Name	Last Name	Birthdate (MM/DD/YYYY)
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Relationship to person requesting the appeal:  
 Self     Spouse     Child     Other \_\_\_\_\_

**Note:** 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.

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

Claim ID Number (Optional)	Reference Number (Optional)	Service Date (Optional)
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Explanation of Your Request (Please use additional pages if necessary.)

**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: **Aetna**  
**PO Box 981107**  
**El Paso, TX 79998-1107**

**Or use our National Fax Number: 859-455-8650**