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/drb/alaskacare/employee/publications/booklet.html; or email the Healthcare Advocates at 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.

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: _____

THE FACTS THAT SUPPORT THIS APPEAL

I think the denial of my claims or precertification request is unfair or improper because:

[Use additional pages if necessary.]

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 _____