MERITAIN® HEALTH
An Aetna Company

Appeal Request Form

NOTE: Completion of this form is mandatory. To obtain a review, submit this form with any necessary information needed to support your appeal. This may include medical records, office notes, discharge summaries, lab records and/or member history (this is not an all-inclusive list). Information can be sent to the address listed on your Explanation of Benefits (EOB) or other correspondence received from Meritain Health®.

Today's Date: _____ **Member Name:** _____

Member ID Number: _____ **Member Group Number:** _____

Patient Name: _____ **Birthdate (MM/DD/YYYY)):** _____

NOTE: authorization form may be required for the appeal if its for another person that's not the member/patient.

Type of Appeal: Medical ☐ Dental ☐ Vision ☐

What are you appealing?

Medical Necessity/Precertification	☐	Coordination of Benefits	☐
Pricing Dispute (amount allowed)	☐	Coding Dispute	☐
Benefit Level (percentage paid)	☐	Exclusion	☐
Pre-Service	☐		

Provider Name: _____ **TIN:** _____

Provider Address (Where appeal/complaint resolution should be sent)

_____

Claim(s): _____ **Date of Service:** _____

CPT/HPCS/Service being disputed: _____

Explanation of your request (please use additional pages if necessary):

Please return to:
Meritain Health Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908